The Impact of the Affordable Care Act on Behavioral Health Services: Who, What, How, Where, and When?

by

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ABSTRACT

The Impact of the Affordable Care Act on Behavioral Health Services: Who, What, How, Where & When?

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Historically, the behavioral health system has been characterized by fragmentation and dissatisfactory access, quality, and cost of care. The Patient Protection and Affordable Care Act (PPACA) of 2010 addresses many of these issues. Objectives: This Community-Based Masters Project analyzed the impact of the PPACA on mental and behavioral health services, with a focus on 5 questions – who, what, how, where, and when. That is, [1] who will deliver behavioral health services, [2] what will behavioral health entail, [3] how will these services be funded, [4] where will these services be delivered, and [5] when will these provisions take effect, according to the PPACA? Methods: Research design consisted of a general literature review followed by policy analysis of relevant provisions in the PPACA; behavioral health-related terms were identified and located in the PPACA, and results were synthesized from relevant sections. Results: Relevant provisions were found in 25 sections of the PPACA. Compared to the behavioral health system at present, the most significant changes impact the definition of behavioral health. Conversely, the PPACA only moderately alters behavioral health service sites, and providers and funding mechanisms not at all. Recurring themes include greater focus on integration, vulnerable populations, research and prevention, and mental health parity, in general. Limitations are also present, and include a lack of third-party review system for new behavioral health programs, a lack of behavioral health input in integrative health initiatives, and the vague, unspecified, or disparate monetary amounts designated for many behavioral health provisions. Conclusion: These provisions are likely to have a positive impact on behavioral health patients and professionals alike. Of course, such success depends on the PPACA being allowed to proceed as it was enacted. Though Pennsylvania may eventually overturn the PPACA, behavioral health advocates and providers should regardless invest in co-locating care services in integrative settings, health homes and patient-centered models of care, behavioral health worker education and training, high-quality reporting systems, and more complete parity overall.

INTRODUCTION

Historically, the U.S. health system has been characterized by fragmentation and dissatisfactory access, quality, and cost of health services, which has further encouraged inefficient care and fragmentation of the system in general. In 2010, the federal government passed H.R.3590 – also known as the Patient Protection and Affordable Care Act, or the PPACA – in order to address some of these issues. While many believe that the purpose of the PPACA is to lower costs and increase access to primary care services, in reality, the PPACA may have far-reaching implications for the delivery of behavioral health services as well. However, whereas the PPACA's effects on primary care have been the source of much speculation and public debate since the bill's passage, how the PPACA addresses specific behavioral health issues has received comparably less attention. As a result, little is known about how behavioral health services and delivery will be affected by the PPACA in upcoming years.

Today, there is a significant need for behavioral health care and improved access and delivery of such services in the U.S. In any given year, about one in five adults will experience a mental health condition that can be officially diagnosed (RAND, 2009). Additionally, up to 20% of children may also have a diagnosable behavioral health disorder, of whom as few as 40% and as many as 80% may fail to receive the necessary care services (Kavanagh et al, 2010). In general, then, the number of Americans suffering from a mental or behavioral disorder approximates 58 million annually, with 22.2 million requiring treatment for substance use disorders, with 6% suffering from serious mental illness, and with 20% of youth being affected by a mental disorder to the degree that impairs daily activity (Mannino, 2010). Currently, common barriers to improved behavioral health services include shortages of behavioral health care workers or providers, and their limited availability for consultation. Health plans may also act as barriers, particularly in cases where coverage is inadequate or altogether lacking (RAND, 2009). While this much is known about the status of behavioral healthcare today, the future of the field may be subject to great change in the upcoming years, particularly in light of recent policies such as the

PPACA, and particularly because the very definition of behavioral health may well change with changes in public policies (Goldman & Grob, 2006).

This Community-Based Masters Project [CBMP] seeks to clarify the future of behavioral health care by identifying the impact of the PPACA on behavioral health services in the U.S. This goal will be accomplished through an extensive review of existing literature to gain an understanding of how behavioral health care developed in the U.S., as well as policy analysis of relevant provisions in the PPACA bill. The goal will be to determine (1) who delivers behavioral health services, (2) what behavioral health actually entails under the PPACA, (3) how the PPACA plans to fund or reimburse for behavioral health services, (4) where behavioral health services will be delivered, and (5) when related provisions in the PPACA will impact behavioral health services. The findings of this study will then be used in symposiums and forums to inform regional health professionals and community leaders on the PPACA's impact on behavioral health services in the Philadelphia region.

SPECIFIC AIM

This CBMP seeks to determine the impact of the PPACA on behavioral health care services and delivery in the upcoming years. To do so, five points of PPACA influence over behavioral health will be described:

- Who will deliver behavioral health services.
- What behavioral health service will entail.
- How behavioral health services will be funded or reimbursed.
- Where behavioral health services will be delivered.
- When new provisions will impact behavioral health services.

The aforementioned objectives will be achieved through the specific aims that follow:

- Evaluate the impact of PPACA legislation on behavioral health.

- Explore and determine the meaning of behavioral health, as a function of political philosophy and public policies in the past and present.
- Determine the characteristics and limitations of the behavioral health workforce, as well as future plans for expansion.
- Determine the designated or most likely future sites for behavioral health care delivery.
- Explore the PPACA's plans for federal insurance and financial reimbursements on behavioral health provision.
- Describe the timeline of PPACA provisions for behavioral health.

RESEARCH DESIGN AND METHODS

Overview

The study design will consist of (1) conducting an extensive review of existing literature, and (2) conducting an in-depth policy analysis of provisions in the PPACA bill relating to behavioral health. Sources were obtained for the literature review from the beginning of this project through completion of data collection in May 2011, using various search engine portals and catalogs located on the Drexel University Library website and database. Analysis and report writing began in December 2010 and terminated in June 2011, prior to creation of the deliverable – a reference sheet outlining PPACA provisions for and impact on behavioral health care – for future use in public and professional forums.

Subjects

This CBMP is a policy analysis and literature review, and as such did not involve human subjects contact or interpersonal data collection. Rather, a total of 32 scholarly and professional references as well as the PPACA were consulted and scrutinized for the development of the literature review and results.

Study Variables and Methods of Data Collection

Variable definition and measurement – Conceptual variables were defined throughout the course of the study. The most important of these variables includes the concept of "behavioral health", which was operationally defined through explanations and descriptions extrapolated from literature reviews. "Behavioral health workers," "behavioral healthcare," and "behavioral health services" were also defined in this manner. Similarly, a lexicon of behavioral health related terminology was compiled through informal discussion with the project's preceptor, using his knowledge and expertise as a foundation on which to begin data collection. The PPACA was read in thorough detail to locate these terms in the bill as well as to extrapolate their significance on behavioral health; the "impact" of the PPACA on behavioral health was then operationally defined through a thorough reading and analysis of current and past policies, and the "significance" of these provisions was conceptualized and developed at the conclusion of literature review and policy analysis.

Instrument development and use preparation – Data was pulled together first from existing literature and then from the PPACA bill as it was passed in 2010. Literature was gathered from all available sources, including but not limited to books, scholarly journals, and online references. The PPACA bill was acquired from the appropriate government database. The data collection process began in October 2010 and ran through January 2011, although the emergence of new documents relating to the PPACA and behavioral health necessitated continued data collection in the months that followed, in order to supply the final report with the most comprehensive and up-to-date information.

Data management and file development activities – Data was managed primarily through digital means on the computer. However, a separate physical folder for relevant handouts, fact-sheets, etc.,

was also kept to ensure a complete collection of files as well as easy access to crucial hardcopy references.

Institutional Review Board Considerations

This project and its protocol were approved to proceed in late January 2011 by the Institutional Review Board [IRB], following submission of a letter of determination (Appendix A) to obtain a release letter for IRB exemption.

Data Analysis

Analysis plan – Following initial literature review, the analysis plan consisted of reviewing and extrapolating significance from the PPACA bill in regards to its impact on behavioral health. Analysis began in December 2010, in conjunction with ongoing data collection and development of data files. Report writing also began at the same time. Both analysis and report writing were scheduled to terminate in April 2011, culminating in a first draft submission to the CBMP advisor on March 19, a final draft submission on June 3, a final poster presentation and exhibit on June 6, and dissemination of findings, an oral defense, and presentations within the Drexel University School of Public Health or in public forums throughout.

Precautions regarding methodological weaknesses and potential problems – Even the most efficient study designs can inevitably have methodological weakness and bias. In order to minimize biases in data collection and management, this study gathered data from several varied sources, and attempted to make a note of questionable authorships and potential conflicts of interest within all referenced sources. Overall, the study attempted to analyze the data and extrapolate its significance in as academic and objective a manner as possible.

Upon completion of the report and the study in general, deliverables and goals to assist in the dissemination process included the following:

- Development of a *guideline or reference sheet* outlining PPACA provisions for behavioral health care and their impact on behavioral health access, costs, and delivery.
- Use of the CBMP narrative in *symposiums and forums* to inform regional health professionals and community leaders on the PPACA's impact on behavioral health services in the Philadelphia region.

BACKGROUND AND SIGNIFICANCE

In order to understand the full impact of the PPACA on behavioral health care in the U.S., it is first necessary to look at past and present factors that have come to characterize the behavioral health system today.

"Who"

In the past, most behavioral health care services were provided by workers in the public sector. At the turn of the 20th century, when local governments were responsible for paying for episodic care, behavioral health services provision was split between state asylums, which were built and run by state governments, and local welfare institutions, which were less costly for local governments to maintain. Following policy changes in the late 1890s and early 1900s however, shifting financial responsibility from local to state governments led to increased behavioral health service provision in state institutions. Patients at this time were considered to be the "indigent insane" and consisted primarily of the elderly, who suffered from dementia or other disabling conditions related to age (Goldman & Grob, 2006).

In the early 21st century however, payment systems and policy changes have generated a very different view of who provides and receives behavioral health services. Today, patients can seek behavioral health care from psychologists, social workers, and counselors (Gray, Brody, & Johnson, 2005), although primary care physicians still provide most of the mental health care delivered in the U.S. In any given year, one in five adults will experience a mental health condition that can be officially

diagnosed, and 40% of these individuals will seek help through the primary care setting initially. Occasionally, primary care physicians may be equipped to diagnose behavioral health conditions. For example, approximately 42% of patients with clinical depression and 47% of those with generalized anxiety disorder in 2000 were first identified not by a behavioral health specialist but by a primary care physician. Similarly, primary care physicians are often the first among healthcare professionals to deal with undiagnosed or asymptomatic adults, with 32% of these adults preferring to be seen by a primary care physician for a mental health issue, compared to 4% preferring to seek help from a psychiatric professional (RAND, 2009).

This patient bias towards behavioral health treatment by primary care physicians points towards several barriers to accessing behavioral health care today. One barrier is the workforce shortage or limited availability of behavioral health providers for patient consultations or appointments. Insurance coverage also poses a barrier, as the extent of coverage depends on an individual's specific health plan. However, the shortage of behavioral health workers has drawn notice from primary care physicians, two-thirds of whom reported in a 2009 survey that outpatient mental health providers were not available when needed. Necessary outpatient mental health services were thus unobtainable two-thirds of the time. This rate is at least twice as high for behavioral health care compared to that of other health field services. Together, these issues suggest that limitations to behavioral health provider availability are not simply due to problems in filling the behavioral health workforce, but may vary greatly depending on patient characteristics and the nature of treatment itself (RAND, 2009).

Because primary care physicians are often the first to see and identify patients with behavioral health problems, workforce shortages in primary care also act as a barrier to behavioral health access and provision. One cause of workforce shortages in primary care is the system of reimbursing physician practice in general, such that incentives are greater for specialists than for primary care physicians. As a result, 70% of physicians in the U.S. are specialists, compared to only 30% in internal medicine,

geriatrics, family medicine, or pediatrics. Internationally, studies have linked better health outcomes with more equal proportions of primary care to specialty physicians (Goodson, 2010), thus shortages in the primary care physician workforce present an additional barrier to already problematic shortages in the behavioral health care workforce. In line with the specific aims of this project, this study examines such provider definitions and dynamics, and determines whether and how these definitions and dynamics may change under the PPACA.

"What"

Past attempts to define "behavioral health" have taken either a narrow or broad perspective, an historic conflict that demonstrates how actual definitions have varied and will continue to change based on how public policies regard the scope and severity of health conditions. The problem with securing a stable definition of behavioral health has been that the classifications and prioritization of the severity of disease impairment have changed alongside evolving public policies. At the end of the 19th century, the State Care Acts were the first critical policies relating to "mental illness," centralizing financial responsibility for care of the "indigent insane" with state governments. Previously, when both state and local governments had been accountable for financial responsibilities, local governments were pressured to keep the "indigent insane" in local welfare institutions as a way of minimizing costs. However, after states agreed to shoulder the financial burden, local governments were free to re-define "insanity," and include dementia and other disabling conditions under the category of "mental disorders" (Goldman & Grob, 2006).

Later political actors and policies further shaped and re-defined behavioral health in successive decades. Following the State Care Acts, the next major designation came from the Joint Commission on Mental Illness and Health, established in 1955 by the American Medical Association and the American Psychiatric Association. The Commission's focus was broad, and defined mental illness and health completely, based on the myriad of social, cultural, psychological, and medical factors that contribute to

disease etiology. The federal government then passed the Community Mental Health Centers Act of 1963, which also had a broad focus to serve patients of all mental health conditions. However, community mental health centers were eventually criticized by the U.S. General Accounting Office for inadequately addressing the needs of patients with "chronic mental illness." This critique marked a shift in definition from one based broadly on the general population, to one that focused more specifically on what policymakers considered to be more severe illness categories. However, the tension between broader definitions of mental health and narrower definitions of mental illness continued to challenge policymakers in the years thereafter (Goldman & Grob, 2006).

Because so many different interest groups are represented in any debate on behavioral health care, more recent policies have attempted to cover a wide agenda in order to satisfy as many needs as possible. The Mental Health Systems Act of 1980 and mainstream health insurance programs like Medicare and Medicaid have helped to address some broad-focus issues. However, the rest of the 1980s saw a return to a more narrow definition centered on patients with chronic and severe behavioral health issues. Around this time, the term "chronic mental illness" was also changed to "severe and persistent mental illness" to appease advocates and patients who were attempting to eliminate the stigma associated with seeking behavioral health diagnoses and services. Moreover, changes in criteria for "mental disability" paralleled changes in the structure of financing public mental health services. The primary goal of this change was to improve Medicare outpatient coverage for Alzheimer's disease patients. As it turned out, in the process of restructuring payment systems for one condition, coverage was achieved for all mental disorders, with the result that coverage for behavioral health services was expanded for Medicare and Medicaid recipients (Goldman & Grob, 2006).

The fact that present policies have the power to shape definitions and perceptions of behavioral health cannot be emphasized enough, as today, "behavioral health" may have different meanings and implications depending on how the term comes to be defined by the PPACA. At the moment, some use

the term interchangeably with “behavioral medicine.” This interconnected view of various behavioral health terminologies arose from various post-World War II influences, which encouraged interdisciplinary alliances between psychiatry and clinical psychology. More generally speaking, the result was a growing relationship between research and practice. However, not all individuals use these terms synonymously but rather may consider behavioral health to be a subspecialty of behavioral medicine. Within this framework, “health” indicates a greater focus on maintaining general health and preventing behavioral issues in healthy individuals, while “medicine” designates more wide-ranging aspects of the behavioral care field, including disease education, scientific inquiry, and medical practice (Matarazzo, 1980). Professionals in behavioral medicine thus have a more individualized focus, directing their attention to a patient himself more so than to the familial, educational, work, community, or political influences on that patient’s behavior (Keefe, Buffington, Studts, & Rumble, 2002).

For the purposes of this study, the aforementioned definition is not the one that will be used. Rather, “behavioral health” will be used as a catch-all term that is inclusive of human mental and emotional dysfunctions as well as behavioral issues. This framework is in line with historic concerns with satisfying the needs of a wide agenda, and maintains that daily personal behaviors confer risk for prevalent and often very serious health threats. In this approach, behavioral interventions play a larger role than in the previously described model of behavioral medicine. Here, risk reduction and prevention take into consideration lifestyle influences and the social environment, as well as psychological factors such as negative emotion and stress. In fact, psychosocial factors are considered to be critical to the overall influence and management of disease, be it acute or chronic (Smith, Kendall, & Keefe, 2002).

This study adopts the stance that health and illnesses of the mind and body are often inseparable, and behavioral health is an integral part of overall health and wellness. As such, mental health and substance use concepts also fall under the larger construct of “behavioral health” (Patient Centered Primary Care Collaborative, 2010). If distinctions must be made, the terms “mental health”

and “mental illness” may best be explained by on the definitions given in the 1999 U.S. surgeon general’s mental health report:

> “Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and an ability to adapt to change and to cope with adversity… [while] mental illness is the term that refers collectively to all diagnosable mental disorders… [or] health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning” (Goldman & Grob, 2006).

However, this study uses “mental health” interchangeably with “behavioral health,” since the range of topics in the “behavioral health” umbrella, as defined in this study, covers a far broader scope than does the previously discussed “behavioral medicine” terminology. In the context of this study then, “behavioral health” accounts for not only individual physiology and interventions in primary care, but also culture, public policies, and traditional medical methods and contexts for conducting research across various diseases and disorders (Smith et al., 2002). Past efforts to reform the behavioral and mental health systems, individually and in combination, have benefited overall from a broad definition such as the one utilized in this study, and while definition does not necessarily dictate a solution, there are likewise benefits to the PPACA adopting a broad-based perspective, in general, for defining and re-shaping behavioral health care, as will be explained later in this study.

“How”

The next question that the PPACA must address is how individuals seeking behavioral health services will be insured for care, and how behavioral health services themselves will be funded. Historically, individual health insurance markets have failed to provide satisfactory coverage for those undergoing treatment for mental illness. These shortfalls have spurred state and federal governments to regulate, improve, and secure coverage for such patients in the past 30 years and thereafter. One major concern

in the past was that insuring behavioral healthcare would give rise to the "moral hazard" problem (McGuire & Sinaiko, 2010), in which the acquisition of insurance coverage results in a reduced preventive effort and greater, unnecessary usage of care services, or a preference for using more expensive care technologies (Zweifel & Manning, 2000). However, recent advancements such as improvements in diagnostic assessment, availability of lower-cost treatment, and the evolution of managed care have lessened moral hazard concerns in the behavioral health field (McGuire & Sinaiko, 2010).

A second historical insurance concern, and one that remains a key issue for health insurers today, is adverse selection (McGuire & Sinaiko, 2010), by which individuals who are most likely to benefit from insurance are also more likely to purchase insurance. This situation is problematic because adverse selection, like moral hazard, destroys insurers' ability to pool losses, and therefore drives healthcare costs to higher levels than would otherwise be expected (Gapenski, 2009). Ideally, health insurance should minimize financial risk for insured patients, and be priced fairly and equally for the ill and healthy alike. Within this ideal, healthcare for individuals of lower socioeconomic status should be subsidized if possible, and patients with more chronic health conditions or worse health statuses should pay equal amounts for coverage as insured patients in perfect health. Adverse selection, however, acts as an incentive for insurers to offer low-quality behavioral health care and limit access to insurance coverage, particularly for those with worse mental health statuses (McGuire & Sinaiko, 2010).

As for funding behavioral health services themselves, prior to the 1980s, behavioral health programs were funded categorically by grant-based rather than mainstream health or social welfare programs. Significant grant programs during this time included the Community Mental Health Centers program, the Community Support Program, and the Mental Health Systems Act, each of which was an important funding source when first enacted. However, the problem with using a grant program over a mainstream health program is that Congress must periodically re-approve all grant programs for

authorization and appropriation. Unfortunately, appropriations for continued provisions rarely pass Congressional approval, and often no appropriations were made at all for many historic programs and provisions. Almost every single provision in the Mental Health Systems Act, for example, was repealed by the Omnibus Budget Reconciliation Act of 1981 and replaced with Reagan's block grant. Thus before 1981, reimbursement systems did not sufficiently support or sustain the continued development of high-quality behavioral health services and programs (Goldman & Grob, 2006).

Managed care organizations, also rising to power in the 1980s, played an additional role in payment systems and divisions in the behavioral health system today. In its attempts to curb rapidly climbing costs of mental health care, managed care introduced the idea of "carve-outs," which isolated behavioral health from the rest of medical science, and placed it in the hands of specialty organizations to manage. The resulting managed behavioral health care organizations [MBHCOs] have succeeded in reining in the costs of mental health care, though carve-outs are not without negative consequences. First, because a more costly piece of the health care system has been shifted in one direction, the incentive is for participating care organizations to counteract by pushing patients towards primary care services, which MBHCOs are not responsible for reimbursing. Second, carve-out systems do not address rising pharmaceutical costs, nor do they account for duplicated administrative duties that arise from fragmented care. This latter point leads into the most important problem with carve-outs, which is that such systems encourage further fragmentation of an already broken and increasingly inefficient health system. In light of these disadvantages, focus is now turning towards greater integration in the future through "carve-in" systems, which effectively re-introduce behavioral health into the health care system at large (Gray et al., 2005).

After the 1980s, changing definitions and policies for behavioral health led to efforts to improve mental health benefits and coverage in public programs. After implementation of the National Plan in the 1980s, several criteria changed regarding the nature of disabilities arising from behavioral illness. As

a result, Medicaid was expanded to include psychosocial rehabilitation services, and annual limits to behavioral health benefits were eliminated from Medicare. Having expanded behavioral health care services for its beneficiaries, Medicare and Medicaid became the backbone of financing public behavioral health care, though changes were eventually made to better accommodate behavioral health needs. In terms of inpatient care for example, the use of diagnostic-related groups [DRGs] in Medicare's prospective payment system required alteration after diagnostic and DRG-based evaluations were found to be limited in their ability to adjust for differences in case-mix and to predict costs for inpatient care. These limitations were especially evident in psychiatric inpatient facilities, which led to the eventual exclusion of specialty psychiatric inpatient care and hospitalization from Medicare prospective payments (Goldman & Grob, 2006).

Attempts were also made to improve Medicare outpatient coverage for behavioral health services. These efforts arose from policy concerns that were voiced in regards to Alzheimer's disease, by the Departmental Task Force on Alzheimer's disease in 1984. Their recommendations focused on reducing financial burdens and economic barriers to Alzheimer's disease treatment. Given how Medicare was written at that time, mental health services had a $250 annual limit as well as 50% copayment for psychotherapy and service usage, but due to the multitude of behavioral complications related to Alzheimer's disease, "appropriate treatment" was often too costly to be sought by patients. To improve access to comprehensive Alzheimer's care, Medicare coverage was then changed so that the annual limit and copayment requirements would no longer apply to outpatient and "medical management," or routine office visit, services and care (Goldman & Grob, 2006).

These narrow changes to Alzheimer's reimbursement helped pave the way for broader policy changes in the years thereafter. The 1987 Omnibus Budget Reconciliation Act raised the annual limit of Medicare reimbursement from $250 to $1,100. Medicaid financing was further improved for physician-provided medical management services, which were exempt from the annual limit and only had a 20%

copayment for office visits that dealt primarily with psychotropic drug prescription and monitoring. Although the 50% copayment for psychotherapy remains unchanged, the annual limit on outpatient behavioral health services was removed altogether in 1990, thus progress continues to be made (Goldman & Grob, 2006).

Prior to this study, the PPACA's role for federal reimbursements in inpatient and outpatient behavioral health care had yet to be clarified, though it was clear that insurance coverage for behavioral healthcare was a primary target for the PPACA. Universal coverage attempts to relieve patients of the rising costs of both behavioral and general health care. One study showed that annual spending for behavioral health care is higher for patients with self-ranked "fair" or "poor" mental health statuses, compared to patients in "good," "very good," or "excellent "mental health. For example, in the private insurance market, less mentally healthy individuals pay an average $737 more per year than do individuals with better mental health, who pay an average of $111 annually. These disparities extend to overall health spending as well, with the less mentally healthy paying an average annual total of $7,406 for healthcare, versus $2,778 for those in better mental health. Of the extra $4,628 spent by those in ill mental health, only $626 goes towards direct mental health care costs. Yet obtaining insurance may do little if the coverage itself is incomplete. For example, even in 2000, inpatient behavioral health care was only covered by 63% of individual insurance plans, and outpatient behavioral health care only by 48% (McGuire & Sinaiko, 2010). In order to significantly reform behavioral health insurance then, the PPACA must first address longstanding barriers to efficient coverage and cost containment strategies, and in line with its specific aim, this study sought to find such evidence.

"Where"

Like the "who," the "what," and the "how" described above, the "where" of behavioral health care has changed tremendously over the past century. Historically, behavioral health services have tended to be separate from general health services. One reason is that different subpopulations may be subject to

different policies and programs, and are therefore frequently served by different organizations and institutions. Another reason is because policies for and definitions of behavioral health are constantly changing. For instance, recall that in the past, the enactment of the State Care Acts shifted financial responsibility from local to state governments. At that time, there was a corresponding re-definition of "insanity" to include dementia and other mental conditions related to old age. Consequently, the start of the 20th century saw the physical transfer of elderly patients from almshouses to state institutions in what was to become the beginnings of nursing home care (Goldman & Grob, 2006).

As with changing policies and definitions, changing payment and reimbursement systems also have an effect on where behavioral health services are provided. In the 1980s, small, incremental policy changes in the nature of public sector care led to an expansion of psychosocial rehabilitation services covered by Medicaid, as well as a shrinking of annual limits to behavioral health benefits in Medicare. Around the same time, Social Security Insurance, Medicaid, and Medicare became integral components of financing public behavioral health services. Due to improved income supports for behavioral health care over time, community programs were able to expand, and institutions such as the community mental health center, first, and state hospitals, second, became key sites for service provision throughout the latter half of the 20th century (Goldman & Grob, 2006).

Today, behavioral health service delivery may occur in a wide variety of locations, including solo practitioner, mental health center, community, and integrated care settings (Gray et al., 2005); however, with primary care physicians providing most of the mental health care delivered in the U.S., the primary care setting is frequently the initial – and sometimes only – portal to behavioral health services and care (RAND, 2009). Behavioral health specialists may sometimes also be co-located in primary care settings. Unfortunately, the quality of care by co-located professionals is currently undocumented, and the success rate of various treatment options within these settings is undetermined at present (Gray et al., 2005).

As for actually being able to obtain these services, private insurance frequently covers patients who are employed, and those for whom behavioral illness is not chronically disabling. These patients thus have access to private providers and agencies for behavioral health care. For patients with less severe mental disorders, treatment is often sought in a general medical setting, or in other community locations like schools and workplaces (Goldman & Grob, 2006). It is also important to consider shifts in disease definition, provider type, and payment structure, which may emphasize treatment at one type of site over another. As a result of these external factors, it is difficult to predict where behavioral health services will be provided in the future, although this study does attempt to establish a standard or typical location for future delivery of care, in accordance to this project's specific aim.

"When"

Significant changes have been occurring in the history of behavioral health care since the late 19th century (Goldman & Grob, 2006), and will continue into the future with the PPACA. The Congressional Budget Office estimates that, as a result of implementation, a total of 24 million individuals will have become insured through an exchange by 2019. In the meantime, the formation of a multi-stakeholder Workforce Advisory Committee, and increased funding for education and training for both primary care and allied health professionals are set to begin by fiscal year 2010 (The Henry J. Kaiser Family Foundation [KFF], 2010). These provisions may help address – if not completely answer – questions of "who" the next professional generation of behavioral health workers will be, and "what" behavioral health may encompass in the future.

The PPACA is also expected to tackle issues of "how" behavioral health care might be financed under new reform policies. Changes in Medicare and Medicaid will come into effect as early as fiscal year 2010 (KFF, 2010), and the newly created PPACA insurance exchanges are scheduled to become operational on January 1, 2014 (McGuire & Sinaiko, 2010). With Medicaid in particular, a Community First Choice Option will be established in order to "provide community-based attendant supports and

services to individuals with disabilities who require an institutional level of care" (KFF, 2010). Of course, it is unclear whether these "disabilities" and "institutional levels of care" will encompass behavioral health conditions in the future, and the consequences of other PPACA provisions to address "how" questions of behavioral health remain unforeseen at this time.

Finally, there is indication that the PPACA may address questions of "where" behavioral health services will be provided in the future. One way that the PPACA may accomplish this is through the provision to increase funding to the National Health Science Corps and community health centers, by $11 billion over 5 years, effective starting fiscal year 2011. Even before that, fiscal year 2010 expects to see the development of new programs in support of nurse-managed health clinics and school-based health centers. Collectively, these measures are intended to expand access to care. However, as with the Community First Choice Option for Medicaid (KFF, 2010), it is thus far unclear whether actions like increased funding to community health centers and developing new health clinic programs will have anything to do with encouraging behavioral health access specifically. Nevertheless, this study sought to piece together a general timeline during which such provisions might or should take effect.

RESULTS

Where behavioral health provisions are mentioned within the actual content of the PPACA, the incidence and rate of occurrence of certain terms are themselves indicators of the level of priority assigned to behavioral health-related provisions in the legislature (Appendix B). In all 906 pages of the bill as it was passed, the term "mental health" occurs 49 times, to varying degrees and with varying significance across 25 sections and across 7 of the 10 Titles of the PPACA (Appendix C). Similarly the term "behavioral," as in behavioral health or care, appears 50 times. "Psychiatric" and "psychiatry," which suggest a more medical focus but are nonetheless subsets of mental health care terminology, appear 23 and 6 times, respectively. Finally, more specific disease terminology such as "depression" and

"dementia" appear only 14 and 12 times, respectively. Cumulatively then, behavioral health-related terminology appears 154 times in 906 pages (The Patient Protection and Affordable Care Act of 2010 [PPACA], 2010).

This word count – and therefore the legislative focus on behavioral health provisions – may seem plentiful but is in reality sparse compared to that of other provisions in the PPACA. A quick examination of other key terminology proves this point. The term "prevent," as it references various prevention-related terms, appears 444 times throughout the entire bill, far outpacing the total occurrence of behavioral health-related terms. To provide another example, the term "employee" appears more than 180 times in the first 150 pages alone, also apparently outstripping the occurrence of behavioral health-related terminology. This word count indicates that employee-related coverage occupies a significant portion of the legislature, or is at least a dominant focus of the legislature early on. On the other hand, "retirement" and "retiree" appear 28 and 18 times respectively throughout the entire PPACA. The word count for retirement-related terminology totals 46 (PPACA, 2010), but while these terms are in no way inclusive of all employee-related provisions, their scarcity suggests that such provisions are even less of a focus than those of behavioral health, based solely on terminology as an indicator of legislative focus.

When behavioral and mental health is first explicitly mentioned in the PPACA, it is in Section 1302, entitled "Essential Health Benefits Requirements." Within this context, the legislature includes mental health services as a mandatory subset of "Essential Health Benefits" to be provided as a part of qualified health plans. 'Qualified health plans' are certified by the federal government for meeting certain standards of criteria, and attempt to equalize the cost of premium rates for insurance plans whether offered through an insurer, an agent, or the "exchange" (PPACA, 2010). These exchanges are new, state-based private health insurance markets that consolidate and regulate individual and small-group health insurance, based on two previous models: the 2006 Massachusetts Connector, and the

1960s Federal Employees Health Benefit Program. Loosely modeled on these two paradigms, PPACA exchange markets strive to foster greater market freedom and give patients more options for coverage (McGuire & Sinaiko, 2010).

Through expanded market options, exchanges have the potential to not only increase enrollment in health insurance plans but lower costs for coverage due to increased market competition. Exchange plans are expected to be more generous than individual plans that have been offered in the past, and will include a minimum benefit package in their coverage (McGuire & Sinaiko, 2010). As such, exchanges represent a major expansion of health insurance coverage overall. It is therefore significant that mental health is to be considered not only a mandatory piece of all qualified health plans but an "essential" benefit in these exchanges (PPACA, 2010). In this regard, the PPACA confers new importance upon mental health care, and politically affirms the necessity of such coverage.

The next mention of mental health occurs in Section 1311 and discusses affordable health benefit plan options with respect to mental health parity. This provision refers to Section 2726 of the Public Health Service Act [PHSA] (PPACA, 2010), previously known as Section 2705 and entitled "Parity in Mental Health and Substance Use Disorder Benefits." The PHSA provision widens mental health coverage to an extent that matches the lifetime and annual limits, financial requirements, treatment limitations, availability of coverage information, and various employee and cost exemption determinations and notifications accorded to medical and surgical coverage (Office of the Legislative Counsel [OLC], 2010).

The PPACA leaves most of this previous bill untouched; changes, where they exist, expand PHSA mental health coverage benefits from group health plans to those that are offered to groups or individuals by a "health insurance issuer" (OLC, 2010), and extend PHSA parity benefits to the PPACA's new qualified health plans. The significance of including mental health provisions in this Section of the PPACA lies in the extension of mental health parity. As with designating mental health as an "essential

health benefit," Section 1311's provision for mental health parity attempts to elevate mental health care to the same level of value and regard as medical and surgical care. However, while Section 1311 does extend previous parity benefits to current provisions in the PPACA, the Section occupies only four lines of text in the entire bill and does not revise, strengthen, or otherwise improve upon the actual content of PHSA provisions (PPACA, 2010). The struggle for mental health parity is not a static one though, and the need for such a Section in current health reform efforts is a reminder that parity remains a legislative challenge and a concern of policymakers today.

Although Section 1311 fails to build upon previous parity provisions, the issue of mental health parity reappears in Section 2001, which deals with Medicaid coverage for populations with the lowest income in the U.S. Part of this parity provision requires "minimum essential coverage" to include mental health services in Medicaid benchmark benefits. The remainder of this Section exists to ensure that PPACA provisions are in compliance with financial and treatment requirements set forth by the Section 2705 parity clause in the PHSA. Of course, Section 2001 only specifically applies to non-Medicaid managed care organizations that provide benefits for medical and surgical as well as for mental health and substance use disorder treatments. While this Section is commendable in its specificity, the fact that requirements for broader or more large-scale compliance are excluded from this Section makes it difficult to assess the true state of mental health parity and thus achieve such parity in the future (PPACA, 2010).

Whereas parity efforts have been a large part of mental health legislation in the past, even more interesting is the direction in which mental health may be headed – quite literally, in fact, with Section 2703 of the PPACA parsing out a place for mental health care in the "health home" model. Health homes are coordinated state options for enrolled patients who have chronic conditions and require health home services. Qualifying patients are defined as individuals who are not only eligible for State-sponsored medical assistance but who also have 2 or more chronic conditions, 1 chronic condition with

a threat of a second, or 1 “serious and persistent” mental health condition. Under this definition, mental health conditions and behavioral issues such as substance abuse disorders qualify as “chronic conditions.” State-designated providers must likewise meet certain standards for qualification, and can be an individual provider, a team of health professionals supporting such a provider, or a home health agency. Additional providers that may be designated include physicians, clinical groups, and most notably for the purposes of this study, behavioral health professionals and even community mental health centers (PPACA, 2010). Section 2703 is therefore significant not only for re-defining mental and behavioral health concerns as “chronic conditions,” but also for empowering behavioral health professionals and community mental health centers in a way that is not entirely at odds with traditional medical and surgical care.

Indeed, within the health home model, mental health reform manifests itself in Section 2703 through efforts to coordinate more comprehensive care for patients enrolled in health homes. More explicitly, this provision asserts that states participating in health homes must consult and coordinate with the Substance Abuse and Mental Health Services Administration [SAMHSA] (PPACA, 2010). In this manner, it is assumed that states can more effectively or efficiently address, treat, and possibly even prevent mental illnesses or substance abuse issues within patients with chronic conditions enrolled in health homes. As such, this Section is a step towards greater integration between traditional medical care and mental health care. However, the addition of this clause is also an indicator that efforts are needed – and have long been needed – to better coordinate and integrate mental health benefits with medical-surgical treatment, follow-up, and transitional care. Consequently, this clause is also a reminder that truly integrated physical and mental health care is far from the norm, and that states are not yet in the process of implementing integrated care so much as merely communicating the need for such integration.

Commendably, the PPACA continues to take additional strides towards integrated care in Section 2707, which discusses the formation of Medicaid emergency psychiatric demonstration projects under the Secretary of DHHS. In accordance with this provision, State Medicaid plans provide payment to private "institution[s] for mental diseases," for Medicaid-eligible individuals between the ages of 21 and 65 who require stabilization for an "emergency medical condition." This PPACA provision adopts its reimbursement assessment based on previous legislature, specifically Title XIX of the Social Security Act [SSA] (PPACA, 2010), which provides grants to states for government medical assistance programs, such as Medicaid and State Children's Health Insurance Program [CHIP]. Under SSA Title XIX, Section 1900, the Medicaid and CHIP Payment and Access Commission [MACPAC] reviews Medicaid and CHIP payment policies in various sectors to determine access to and quality of care for beneficiaries, and creates an early-warning system that indicates areas with provider shortages or other issues that threaten the health of Medicaid and CHIP beneficiaries (Social Security Administration [SSAdmin], SSA §1900, 2011). The PPACA's adoption of SSA Title XIX policies thus subjects all providers participating in the Medicaid emergency psychiatric demonstration project to MACPAC standards for payment and future scrutiny.

Title XIX of the SSA extends beyond payment policies and assessment, however, and continues on in Section 1910 of the SSA, to deal with the certification of intermediate care facilities and rural health clinics used expressly for "mentally retarded" individuals. Section 1910 sets important standards for assessing and certifying rural health clinics and intermediate care facilities for mental and behavioral care. These standards are outlined in Sections 1902(a)(31) and 1905(d) of the SSA, and clinics and facilities that do not meet these criteria can have their approval revoked (SSAdmin, SSA §1910, 2011). These criteria indicate that an "intermediate care facility for the mentally retarded" is an institution or a distinct part of that institution, which is designed to primarily and actively service those with mental health or rehabilitative care needs (SSAdmin, SSA §1905, 2011). Regarding individuals seeking care, these criteria require that the facility provides a written plan of care for each patient prior to admission

or authorization of services. An independent professional program must also review the patient's medical and continued need for services at that facility (SSAdmin, SSA §1902, 2001).

It should be noted that the PPACA includes Section 1905(d) of the SSA, which relies on an antiquated payment structure for care in these institutions. Basic payment schemes as described by Section 1905(d) may still be used in some less modernized intermediate care facilities in the nation, institutions today generally use more evolved payment structures that better account for more recent movements towards integrated care and delivery in the mental health system. The PPACA, however, only briefly includes Section 1905(d) of the SSA in an attempt to highlight the need for a change in the mental health care payment system. Health reform, as it was passed, does not attempt to revise or propose any changes to these funding methods in intermediate care facilities. The result is that this part of the PPACA provision is vague and empty, with no real changes suggested. Of course, the explanation for such an open-ended clause may lie in the fact that the reformed health system had not yet been fully built at the time the PPACA was written, neither had updated or more appropriate funding methodologies been approved; consequently, payment provisions for health reform were left vague in order to accommodate changes in funding that would inevitably be proposed following passage of the PPACA. The premise was that payment reform would ensue as a result of health reform. However, opponents have continued to battle the PPACA as a whole since its passage in 2010, hence there has been little opportunity to extrapolate the details of payment reform under the new system, or ensure that new payment systems keep pace with delivery systems to incentivize the provision of more integrated care.

Influence from the SSA does not stop at payment and certification guidelines, as Section 2707 of the PPACA goes on to adopt standards established by Section 1867 of the SSA, under which mental institutions participating in the Medicaid emergency psychiatric demonstration project must comply. Section 1867 of the SSA establishes guidelines for hospitals with emergency departments to provide

medical screening, treatment, and stabilization services for individuals with emergency medical conditions and women in labor (SSAdmin, SSA §1867, 2001). Only after all SSA guidelines are met do mental institutions become eligible to participate in the Medicaid emergency psychiatric demonstration project, and to stabilize – but, notably, not to provide continuous care for – appropriately-aged individuals seeking care for an emergency medical condition under such a plan.

The responsibility granted by Section 2707 of the PPACA is very limited in scope though, and is by no means inclusive of all mentally ill individuals. These provisions only apply to individuals who qualify as having an emergency medical condition – that is, one who expresses suicidal or homicidal thoughts or actions, and who is designated a danger to self or others. Furthermore, treatment is not necessary, only stabilization, such that the emergency medical condition no longer exists, and the individual is no longer considered a threat to himself or those around him. States will establish their own mechanisms for determining whether stabilization has been achieved, using options like utilization review, authorization, management practices, and medical criteria to evaluate behavioral health status prior to an inpatient's third day of stay.

Section 2707 provisions are important measures to help fill the gaps in emergency mental health care, but they are by no means comprehensive, and many actual details are left to state discretion. Only states which applications are approved and which contribute to a balanced geographic distribution will participate in this 3-year demonstration project. Overall, appropriated funds will be made available through December 31, 2015, and $75 million is planned for appropriation towards this project in fiscal year 2011. The exact amount to be paid to states each quarter will total the amount of quarterly federal medical assistance percentage of expenditures. In return, participating states will collect and report relevant information back to the federal government in order to facilitate evaluation of the demonstration project and eventual reporting back to Congress. The goal of this surveillance is to determine the impact of such demonstration projects on the mental and physical health system,

specifically for individuals enrolled in Medicaid. Factors under scrutiny include Medicaid-users' level of access to inpatient mental health services, average duration of inpatient stay, emergency department visitations, and discharge planning by hospitals. Also under assessment are the costs of inpatient, emergency, and ambulatory mental health care under the demonstration project, as well as the rates of Medicaid admission to inpatient facilities through the demonstration project as opposed to through other means. These evaluations are critical, as they help influence whether or not the demonstration project will continue after its initial three-year run, ending on December 31, 2013, to be expanded nationally (PPACA, 2011). As such, the demonstration project represents a more detailed, three-year snapshot of how various components of the mental health systems are functioning around the U.S. today.

The PPACA sections described thus far have focused on reforming the mental health care system more generally, as a whole, and provisions relating to more a specific mental condition are finally discussed in Section 2952, which explains the PPACA's plan for providing support, education, and research for postpartum depression or psychoses. Efforts to study postpartum depression will be expanded, and will include clinical research on etiology as well as epidemiological studies on disease frequency in relation to racial influence, and improved screening and diagnostic techniques. A national longitudinal study is also planned from 2010 through 2019 to evaluate the immediate and long-term mental health effects on women for resolving a pregnancy in various ways. Meanwhile, on the education side, informational programs will also be disseminated for health professionals and the general public as part of a coordinated, national campaign to increase awareness of postpartum conditions and their screening processes (PPACA, 2010). This educational goal marks a major effort towards advancing prevention practices, and is therefore a key provision for public and behavioral health professionals.

Section 2952 offers additional answers in the way of funding mental health care, by providing grants for services to individuals experiencing a postpartum as well as their families. These grants are made possible through an amendment to Title V of the Social Security Act, making the establishment, operation, coordination, and delivery of mental health services more cost-efficient to affected individuals. These PPACA grants will be provided above and beyond other payments made to states by the Social Security Act, and may be integrated in other relevant bills such as Section 330 in the Public Health Service Act. Eligible entities include public or nonprofit private hospitals, public-private partnerships, community-based organizations, hospices, ambulatory care facilities, community health centers, migrant health centers, and homeless health centers. The goal is to advance these entities' ability to diagnose, manage, and educate not only those individuals with a postpartum condition but also those at risk for developing one in the future, and to do so expediently before individuals leave the care facility. Other areas of delivery that Section 2952 seeks to enhance include inpatient and outpatient services, home-based health, and even indirect components like transportation services, financial assistance, and insurance counseling (PPACA, 2010).

Like the research and educational provisions before it, the grant provision in Section 2952 represents an effort to make care for postpartum conditions more comprehensive and cost-effective, and broaden the extent of public health services in the mental health arena. With $3,000,000 apportioned for fiscal year 2010, this Section provides the opportunity for significant economic assistance for approved entities. Unfortunately, the PPACA does not outline exact amounts for fiscal years 2011 and 2012, reflecting, perhaps, the uncertainty surrounding the sums needed to sustain the provisions in this Section in following years. Additionally, this Section focuses on maternal and child health, as mothers and their children are considered a subpopulation with special health needs that exceed those of the general population. Historically however, maternal and child health has received little due attention. Although efforts at reforming the U.S. health system should not limit their focus to

mental health for mothers and children alone, it is nevertheless notable that the PPACA recognizes and allocates grants for a traditionally overlooked subpopulation such as this.

These efforts to improve the quality and efficiency of mental health care are part of an overarching effort to improve the nation's health care system overall, outlined in Title III of the PPACA. Title III begins with efforts to transform the delivery system in the U.S., with Section 3012 focusing on a national strategy to improve the health care system through a newly formed Interagency Working Group on Health Care Quality. The Working Group is composed of senior-level representatives acting on behalf of numerous health-related federal organizations, among which includes SAMHSA. SAMHSA representatives will collaborate and consult with 23 other federal agencies and representatives in streamlining the quality assurance and reporting process in the health care system as a whole, in accordance with national priorities set forth by Section 399HH(a)(2) of the PHSA (PPACA, 2010). Because one of the Working Group's objectives is to assess the degree of quality alignment between public and private sector initiatives, it is implied that the next step in the health reform process is to raise the quality of care and delivery for those entities that are found to be operating below the assessed standard.

Along with improvements in the delivery system, Title III takes steps to improve Medicare for mental health patients and providers. Section 3107 extends the physician fee schedule, as outlined by the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008, to include a mental health add-on (PPACA, 2010). The specific amendment is made to Section 138(a)(1) of MIPPA, which was originally enacted to adjust for mental health payments under Medicare, by furnishing a physician fee schedule as dictated by Section 1848 of the SSA. Psychiatric therapeutic services that were covered by this schedule included insight-oriented, supportive, behavior-modifying, and interactive psychotherapies in inpatient and outpatient facilities and hospitals, partial hospitals, and residential care facilities (MIPPA, 2008). Following the passage of the PPACA, the types of mental health services covered under

the fee schedule have remained unchanged, but the deadline for MIPPA's 5% increase towards this schedule has been extended from December 31, 2009 to December 31, 2010 (PPACA, 2010). Although this extension reflects a relatively small adjustment to provisions made in MIPPA, the underlying significance of this change perhaps reflects a growing recognition that previous payment schemes have been insufficient to accommodate patient demand for Medicare mental health services, or physician demand for satisfactory reimbursement of care. The extension is thus a placeholder of sorts, one that anticipates revised Medicare physician payments in the future.

Further payment reforms are indicated in Section 3502, which also discusses quality improvements through improved payment methodologies. The focus this time is on the patient-centered medical home, with the provision specifically providing grants or contracts to eligible care entities that establish a program in support of primary care practices. Capitated payments will be made to primary care providers directly, in order to establish health teams consisting of community-based, interdisciplinary health professionals from various health fields, whose support is intended to drive quality, cost-effectiveness, and culturally-appropriate care in the patient-centered medical home. Social workers and other behavioral and mental health providers are among those professionals who may be included in an entity's health team. One of the health team's stated goals is to establish an early identification and referral system for children at risk for behavioral problems. Such a system might coordinate info-lines or other relevant health information technologies, to be provided during 24-hour care management and support during transitions in various care settings. Additionally, providers, patients, caregivers, and authorized representatives will also have access to discharge planning and counseling support, as well as referrals for further mental and behavioral health services (PPACA, 2010).

The collaboration indicated in Section 3502 is intended to improve access, coordination, and integration of care and planning between clinical and community health and prevention services, particularly for individuals with chronic diseases and vulnerable populations such as children (PPACA,

2010); however, this integration is far from complete. The PPACA's plan is for health teams to inform primary care providers, and in that way encourage an interdependency that eventually leads to more integrated health systems in general. Yet behavioral and mental health providers are not compulsorily required to participate in an entity's health team. Neither is there any mandatory requirement for health teams to include a behavioral health representative. It is possible that behavioral health considerations might factor into future integration, quality, and payment reforms, but it is equally likely – or even more likely, given the current shortage of behavioral health workers – that health teams will lack mental health support and input. Therefore, unless future health reform also plans and provides for an increase in the mental health workforce, the PPACA's efforts at reform cannot be considered integrated, comprehensive, or even truly interdisciplinary.

As minimal as Section 3502's attempts are in addressing health in vulnerable subpopulations, Section 3509's efforts are even more minimal still. Although attempts are made to improve women's health care, provisions in Section 3509 embody only small amendments to Section 501(f) of the Public Health Service Act. The most important change is the addition of a subsection which states that SAMHSA has the power to establish an Office of Women's Health within its control (PPACA, 2010). Doing so creates an administrative backbone within SAMHSA that might eventually facilitate greater SAMHSA-related coverage of programs for women's mental and behavioral health care, and a greater focus on women's mental health in general. However, Section 3509 does not overtly provide further guidelines, funding, or planning to ensure or assist in the creation of such an office. Left to its own limited resources and with no additional motivation to accommodate such change, it is likely that SAMHSA will continue to prioritize previous issues on its pre-existing agenda rather than further divert its attention to create an Office of Women's Health.

Prevention becomes a greater focus in Title IV, devoted to enhanced public health measures for the prevention of chronic disease. In Section 4011, the PPACA takes some active steps towards

modernizing disease prevention and public health systems through the creation of a National Prevention, Health Promotion and Public Health Council, chaired by the Surgeon General and consisting of various federal department heads. There is no mandate for SAMHSA to be represented on the Council, a fact that yet again reflects the underrepresented, non-integrated nature of mental health with overall health care and delivery in the U.S. Despite this shortfall, one of the Council's goals is to ensure federal coordination of prevention, health promotion, public health, and integrated health care. Secondarily, the Council has an added goal of reporting and making recommendations on the most pressing health issues to the President and to Congress (PPACA, 2010). To truly accomplish these goals in accordance with those of Title IV, however, it is crucial that behavioral health officials be involved to provide an input at the federal level. The current provisions in Section 4011 do not ensure true integration or thorough reporting of this nature, and are therefore inadequate for reforming the mental health system.

To guide the Council, Section 4011 also makes provisions for the formation of an Advisory Group on Prevention, Health Promotion, and Integrative and Public Health, but these efforts also fall short of effecting significant change for the mental health system. The Advisory Group is meant to counterbalance the Council's federal slant by consisting of no more than 25 non-federal, licensed health professionals, to be selected by the president. Their areas of expertise do not include behavioral or mental health support or services, yet one of their duties as members of the Advisory Group is to advise the Council on integrative health care practices. The Advisory Group is also expected to inform the Council annually regarding the nation's progress on health promotion and prevention, specifically to address national priorities for lifestyle behavior modification. As such, the Advisory Group and the Council are expected to be informed on matters involving behavioral and mental health directly, as well as other issues and components of behavioral health dealing with substance use disorder and domestic violence screenings (PPACA, 2010). As with the Council's design, the PPACA takes no measures to ensure

that the Advisory Group will truly be representative of all professionals in various health fields. The unfortunate outcome, then, is that the Advisory Group will be unable to thoroughly inform the Council, which likewise lacks the ability to view the U.S. health system through a critical lens focused on comprehensive, integrated care.

The PPACA makes one final effort to modernize disease prevention and public health systems in Section 4004 of Title IV, which discusses a new education and outreach campaign on preventive benefits. This program is designed around a nationwide private-public partnership that disseminates general health promotion information in order to minimize health disparities and moderate chronic disease. A total of $500 million will be allocated for detailed campaign components, which include media messages, website information, and use of providers to disseminate information within federal health programs – all shifting towards a customized patient-centered model of care that calls for the creation of Internet-accessible personalized prevention and risk-assessment plans. Representing the mental health system, SAMHSA plays a key role as a campaign supporter, providing additional federal resources for preventive mental health care and assisting with consultation and coordination throughout the campaign process (PPACA, 2010). However, in accordance with the overarching campaign goals, SAMHSA's role is limited. Indeed, Section 4004's provisions are inclusive of mental and behavioral health only insofar as to invite but not require additional input and recommendations from SAMHSA. In that sense, Section 4004 unfortunately offers very little in terms of future health system integration, and even less assurance that there will be future change for mental health outreach, education, and prevention campaigning.

Another goal of Title IV is to increase access to clinical preventive services; one area of such focus is in school-based health centers, for which Section 4101 awards grants for facilities and equipment. Priority for receiving a grant is given to eligible entities that serve a large population of Medicaid-eligible children and adolescents inhabiting medically underserved areas, as determined under

titles XIX and XXI of the SSA. Furthermore, Section 4101 amends part Q of title III of the PHSA, by establishing more concrete criteria for school-based health centers. To be considered as such, an entity must provide comprehensive primary care services, defined as physical as well as mental health assessments, diagnoses, treatments, referrals, and follow-ups. Mental health coverage must include behavioral and substance use disorder assessments, crisis interventions, counseling, and treatment. Referrals must also be provided for a full spectrum of services, ranging from community support programs to emergency psychiatric care, inpatient to outpatient, and including other physical health services for standard medical conditions. To qualify as a school-based health center, institutions must provide these comprehensive services during school hours; to qualify for the grant, on-site access is expected not only during normal school hours during the academic year but also year-round, with on-call systems and backup health practitioners providing 24-hour coverage (PPACA, 2010).

From the outset, the provisions in Section 4101 present a more comprehensive and expansive opportunity for mental health coverage and access to vulnerable populations, in this case children and adolescents under Medicaid. However, several problems are foreseen for future health system reform. First, 24-hour access of this nature suggests a concomitant expansion in workforce needed to accommodate more comprehensive and extensive services at school-based health centers. Exact plans for a corresponding increase in workforce has yet to be evidenced, though, aside from a clause stating that grant funds may be used to train additional providers to provide comprehensive care services. Alternatively, investing in and training a new workforce specifically for school-based health centers erodes at awarded grants, leaving less funding available to accomplish the other goals of Section 4101. Furthermore, in reviewing applications from school-based health centers, the Secretary of Health and Human Services is to award grants preferentially to communities that have experienced or are experiencing barriers to access of mental health and substance use disorder prevention services. Also, the requirement for a school-based health center to provide comprehensive primary health services

may be waived for an undefined period of time, assuming a 'showing of good cause' is provided. Finally, although grants are meant to supplement rather than supplant original public funding provisions, the PPACA establishes no sum for appropriation, and defines no such sum for annual authorizations through 2014 (PPACA, 2010). Hence grant provisions, though well-intentioned, have little to no impact on mental health reform thus far, and ultimately depend on the Secretary of DHHS – one individual who, despite the elevated title and level of expertise, may not be as appropriate or as ideally situated to make such determinations as an interdisciplinary advisory group or council of unaffiliated health professionals, for instance.

Section 4201 continues to deal with transformation grants, this time designed with the goal of increasing quality of care in communities. In contrast with Section 4101's goal of increasing community access to clinical preventive services, Section 4201 aims to create healthier communities as a whole, by providing eligible entities competitive grants. Approved state and local government agencies, non-profit organizations, Indian tribes, and national networks of community-based organizations are expected to use this funding to implement, evaluate, and disseminate evidence-based community prevention and health services. To receive a grant, entities must develop a community transformation plan, indicating policy, environmental, and infrastructure changes to promote healthy living and reduce chronic disease rates, secondary disease development, and health disparities in general. Program changes that are relevant for the future of behavioral health include the promotion of social and emotional wellness in school, worksite, and adult community environments. The Behavioral Risk Factor Surveillance Survey may be used to estimate the success of Section 4201 in terms of mental health. Otherwise, annual evaluation measures remain vague, with the PPACA instructing grantees to simply measure community residents' "changes in emotional well-being and overall mental health" (PPACA, 2010).

Of course, many eligible entities may be ill-equipped at present to handle the expectations of Section 4201 or to generate a satisfactory community transformation plan on their own. The Director of

the Centers for Disease Control and Prevention [CDC] is tasked with developing a training program to instruct eligible entities on the interconnected nature of physical and mental health, and the need for comprehensive disease prevention and control strategies to manage these health factors in a community. In line with these objectives, grantees must work together with the Director of the CDC in establishing transformation plans. While interagency cooperation of this sort has the potential to greatly enhance mental health on a community level, an issue still remains on whether sufficient funding can be determined or will even be appropriated to satisfy the needs of Section 4201 in each of its specified fiscal years between 2010 and 2014 (PPACA, 2010). Thus, although it makes a noble attempt at establishing healthier communities, Section 4201 encounters the same technical flaw as in Section 4101; with no established or pre-determined sum for appropriations through 2014, Section 4201's grant provisions, though well-intentioned, may ultimately have little to no impact on mental health reform at the community level.

Another factor for creating healthier communities is the Medicare population, for whom Section 4202 of the PPACA makes provisions under the Healthy Aging, Living Well pilot program. In this 5-year program, grants are allotted to eligible state and local health departments, as well as Indian tribes, to provide public health interventions, screenings, and clinical referrals for individuals aged 55 to 64 in a designated community. This community-based approach represents an opportunity for the federal government to evaluate a community's potential to not only encourage more inclusive service provision in Medicare-aged populations but also to establish integrative relationships between providers, insurers, and patients. Crucial intervention activities under Section 4202 include efforts to decrease substance abuse and improve mental health, as well as to conduct mental and behavioral health screenings, all of which will demand further involvement from mental health professionals. For this reason, eligible health departments may also use grant funds to establish contracts with rural or community health centers and with mental and behavioral health providers. These partnerships will be crucial for treating at-risk

individuals, or facilitating referrals to community follow-up resources and other relevant public programs. These partnerships may also be major components in the success of the pilot program, which will bear annual scrutiny from the Secretary of DHHS (PPACA, 2010).

The effectiveness of Section 4202's pilot program will be measured by observing changes in the prevalence of chronic disease risk factors in new and emerging Medicare enrollees, compared to national and historic data within grantee states or communities. Although the evaluation of evidence, literature, best practices, and resources is still dependent on the Secretary of the DHHS, important health factors to consider include, at a minimum, issues relating to mental health. The scope of evidence review thus compulsorily requires some minimal measure of community mental and behavioral health assessment. The DHHS evaluation must also stand up against independent evaluation by the Administrator for the Centers for Medicaid and Medicare Services [CMS], who will assess the costs of Medicare beneficiaries' usage rates of health services under the pilot program. Thus Section 4202's goal is not simply to enhance mental health care for Medicare populations but to do so in a cost-effective a manner. For evaluation purposes, $50 million will be transferred to the CMS Program Management Account from federal funds established by Sections 1817 and 1841 of the Social Security Act, while grant funds themselves will derive from an undetermined sum to be appropriated each year as necessary from 2010 through 2014 (PPACA, 2010). Due to a lack of certainty for future appropriations though, Section 4202 can be said to harbor the same potential flaw that, as with Sections 4101 and 4201, grant provisions may have little to no impact on mental health reform at the community level.

Using grants to create healthier communities, as listed under Title IV provisions, can only be achieved through an equally fortified healthcare workforce, which is the focus of provisions in Title V of the PPACA. Title V recognizes the shortage of healthcare workforce relative to the healthcare needs of individuals, particularly those in low-income, rural, underserved, uninsured, and minority populations which have traditionally borne much of this nation's health disparities. In response, Title V attempts to

research, provide support to, and enhance workforce education and training, in the hopes that the existing and emerging workforce fulfills patient needs for greater diversity, access, and delivery of care services. For the purposes of Title V provisions, Section 5002 amends Title VII, Section 799B of the PHSA, to include more terms that are relevant to the practice of behavioral healthcare. For example, "mental health service professional" is included to give credence to individuals with a graduate or higher degree from an accredited institution, in a wide variety of behavioral health specialties from psychiatry to psychology, behavioral pediatrics to psychiatric nursing, social work to school counseling, and more. Here, "graduate psychology" is acknowledged as a valid professional health training institution. "Paraprofessional child and adolescent mental health workers" are also included despite the fact that such individuals are not defined as actual mental health professionals but rather represent the first point of contact with those seeking care services.

Section 5101 establishes some further definitions for the purposes of creating a national healthcare workforce commission, as part of a move towards greater innovations in the healthcare workforce in Subtitle B. This workforce commission will serve as a national resource on federal, state, and local levels, in developing and evaluating coordinated training and educational activities that address barriers to integrated care provision and identify the actual need for health care workers. Of 15 possible members serving for 3-year terms and participating in quarterly meetings, only 8 are required to represent all possible health-related categories – and mental or behavioral health professionals not at all. Should a mental health professional participate, though, the workforce commission would find its duties greatly enhanced. Indeed, representation from the behavioral health field is critical if the workforce commission wants to fully develop a fiscally-sustainable, integrated workforce. Furthermore, the commission will recognize national efforts to develop various healthcare career pathways and to communicate key information on workforce recruitment, education, training, and retention in all areas of healthcare. In accomplishing these objectives, the workforce commission must review the current

healthcare workforce supply, demand, distribution, education, training capacity, and special needs of certain subpopulations, and then attempt to predict future needs in 10 and 25 years. With regards to workforce education and training, federal policies on national loan repayment programs, scholarship programs, and educational loans and grants under Titles VII and VIII of the PHSA must also be reviewed in order for the workforce commission to make comprehensive recommendations for workforce priorities and goals, starting 2011 (PPACA, 2010).

Although Section 5101 holds that integrated healthcare workforce planning is among health reform's highest priorities – and it is indeed the workforce commission's first priority, as designated in the PPACA – successful planning and workforce integration is likely to be highly dependent on representation from a behavioral health professional on the workforce commission itself. The same is true of the workforce commission's fourth priority, which deals in part with the mental and behavioral healthcare workforce, specifically in their education, training capacity, projected demands, and integration in the healthcare delivery system overall. Accurate input from the mental health field has further implications for future educational grant programs and financing mechanisms detailed elsewhere in Title V of the PPACA, for which the backbone is thorough data collection and full collaboration with federal staff and consultants. In addition to the likelihood that behavioral health professionals will not be participating on the workforce commission comes the same problem that plagues many of the provisions generated in Title IV of the PPACA: there are no designated sums delineated for appropriation to the workforce commission at present. Although psychologists, social workers, substance abuse prevention and treatment providers, and other mental health professionals now qualify as "health professionals" and are considered a valid part of the "health care workforce" under health reform (PPACA, 2010), there is still no guarantee that the behavioral health workforce will be economically or sustainably integrated with that of the rest of the healthcare system. Thus there is

no guarantee that the behavioral health workforce from this point onwards will show any change whatsoever.

Where aforementioned Title V provisions address definitions and innovations for the healthcare workforce, the remainder of Title V deals with increasing the supply and quality of healthcare workers. Section 5203 attempts to meet the first of these goals by altering healthcare workforce loan repayment programs through an amendment to Title VII, Part E of the PHSA that enhances the current pediatric healthcare workforce. To the PHSA, this particular amendment adds "Subpart 3," dealing with workforce recruitment and retention programs for participating health professionals who are employed full-time for at least 2 years and who provide pediatric subspecialty care – including that of child and adolescent mental and behavioral health – in areas with a definite need that is underserved by the subspecialty. Here, a "qualified medical professional" for child and adolescent mental health care is one who has clinical experience or has completed specialized training in psychiatry, psychology, school psychology, social work, school social work, behavioral pediatrics, psychiatric nursing, marriage and family therapy, school or professional counseling, and substance abuse prevention and treatment. Approved professionals must obviously hold a state license or certification as well. In exchange for contracting out their services, these professionals are eligible to participate in newly created pediatric specialty loan repayment programs run by the Secretary of DHHS, who will arrange to make principal and interest payments of up to $35,000 annually, for up to 3 years of contracted service, towards their undergraduate, accredited graduate, or medical education loans (PPACA, 2010).

There are limitations to Section 5203, however. For example, its provisions are only applicable for those professionals who serve in a medically underserved area, or in areas in which there is a demonstrated shortage of such health professionals. Priority in the loan repayment program will also be given to those professionals who will be working in a school or educational environment, who are familiar with evidence-based, culturally-appropriate methods of care practice, and who demonstrate a

need. Finally, while mental and behavioral professionals are authorized appropriations $20 million annually between 2010 and 2013, it should be noted that pediatric medical and surgical specialists, to whom Section 5203's loan repayment program also applies, are authorized $30 million annually for the same time period (PPACA, 2010). It is presumed that restrictions on work location are designed to help reduce historic health disparities in medically underserved areas, and to ensure that children and adolescent healthcare needs remain the focus of Section 5203. However, the difference in authorized appropriations between mental and behavioral health professionals versus medical and surgical specialists demonstrates a continued prejudice against the mental health field in general, at least from a federal standpoint. The $10 million difference in appropriations can be interpreted as a political indicator and the economic value of traditional medical and surgical services, above and beyond that of mental and behavioral healthcare. Despite the PPACA's earlier efforts at parity, then, the truth is that mental health is still not granted the same degree of political esteem and financial reimbursement as are traditional medical and surgical services.

While Section 5203 attempts to address the supply of behavioral health workers, Section 5301 deals more directly with the relationship between behavioral health and training in family medicine, general internal medicine, general pediatrics, and physician assistanceship. Section 5301 represents a continued effort by Title V, Subtitle D to enhance the education and training of the U.S. healthcare workforce, by amending Title VII, Part C of the PHSA and, among other things, providing 5-year federal grants to accredited medical schools to establish, maintain, and improve clinical teaching, research programs, and faculty and workforce recruitment in the fields of family, internal, and pediatric medicine. At first glance, these goals have little to do with enhancing the behavioral health workforce, but in reality, Section 5301 enhances the behavioral healthcare workforce indirectly. Such enhancement is achieved through preferential grant awards, which will be given to reputable applicants that not only establish or expand their programs but encourage interdisciplinary, integrative, and even innovative

models of primary care. Such models include the patient-centered medical home, chronic disease management teams, and – most importantly, for behavioral health workers – an interprofessional model of care that encourages greater continuity of care alongside the integrated provision of both physical and mental health services. Such a model of care has the potential to increase the ability of physical health providers to recognize, treat, refer, and communicate with patients seeking mental and behavioral services. Finally, in order to receive priority for grants, applicants are encouraged to engage in formal relationship with other clinics for health and health education, and to provide training for care for underserved or vulnerable populations – including individuals with mental health and substance-related disorders (PPACA, 2010).

As a result of Section 5301, primary care workers are expected to be able to better integrate and coordinate healthcare, and to also be trained in cultural competency and greater health literacy. Of course, the exact nature and needs of grant-funded training are additionally subject to recommendations from the workforce commission as established in Section 5101 of the PPACA, which unfortunately is not without its own flaws, as mentioned above. Additionally, in what is proving to be a trend in the PPACA, the exact sum of appropriations for Section 5301 in general is only given for fiscal year 2010, while sums for intermittent years through 2014 remain undesignated. This amount is $125 million to carry out this section's general goals in 2010, with an added $750,000 annually from 2010 through 2014 to integrate various academic and administrative units. What Section 5301 does delineate, though, is that 15% of each annual sum must be allocated to a physician assistant training program in order to promote the primary care practice (PPACA, 2010). These efforts are commendable, given the current shortage of primary care professionals across the nation (KaiserEDU.org, 2011). However, Section 5301 does not promote comprehensive integration. By designating a specific percentage of allocations for physician assistants – that is, 15% – the PPACA is in turn highlighting the corresponding lack of mandatory allocations for mental and behavioral health professionals. There is no guarantee that

allocations will be used to fully or even minimally integrate mental and behavioral healthcare into primary care practices. In this sense then, Section 5301 cannot be considered a direct mechanism for reforming the behavioral health field, but is rather akin to one that reinforces historic tendencies to treat mental and behavioral health as a secondary – and, perhaps, even a minimally relevant – factor for primary care services and health outcomes in the U.S.

Mental and behavioral health education is more directly addressed in Section 5306, which amends PHSA Title VII, Part D, primarily by eliminating Section 757 and establishing a new Section 756 in the PHSA, entitled "Mental and Behavioral Health Education and Training Grants." Under this amendment, grants will be provided by the Secretary of DHHS in order to support recruitment, education, and clinical training for students entering the behavioral health field. Educational programs are eligible for grant funding if they are accredited institutions of higher education or professional training, whose purpose is to establish and expand graduate placement in child and adolescent mental health psychiatry, psychiatric nursing, behavioral pediatrics, substance abuse prevention and treatment, marriage and family treatment, and other programs for professional or school psychology, social work, and counseling. Baccalaureate, master's, and doctoral social work programs, as well as interdisciplinary psychology programs at the master's, doctoral, internship, and post-doctoral residency level, are also eligible for grant funding, in what is presumed to be an effort to make mental and behavioral healthcare more well-rounded and integrated within itself. Finally, state-licensed mental health organizations, both for- and non-profit, can apply for grants in order to fund pre-service or in-service training programs for entering paraprofessional child and adolescent mental health workers. So long as sensitive and non-discriminatory enrollment of students is demonstrated, cultural and linguistic competency is prioritized in the placement process, and federal requests for related data and information are obeyed, an educational institution is eligible for a Section 5306 grant. Notably, in actually awarding a Section 5306 grant, the PPACA itself demonstrates some awareness of the nation's cultural needs and diversity,

designating that at least 4 recipients of all grants for baccalaureate, master's, and doctoral level social work programs be historically black or minority-serving educational institutions (PPACA, 2010).

Although Section 5306 is broadly applicable to a variety of mental and behavioral health education needs, priority for grant awards will be given to those institutions that meet the PPACA's standards for quality in health education and training. For institutions for social work to be given priority, programs must be accredited by the Council on Social Work and must boast a graduation rate of 80% or higher, and its students must be recruited from or go on to serve high-need, high-demand areas. For psychology-related institutions to receive priority, programs must focus on training students to care for the behavioral health needs of vulnerable populations. These populations include children, the elderly, individuals with mental health or substance-related disorders, homeless persons, victims of abuse, trauma, or combat stress, and chronically ill patients and their families. Meanwhile, an institution with child and adolescent mental health programs is given grant priority if it utilizes evidence-based methods and provides data on its number of graduate trainees and the populations and types of areas they served. Additionally, child and adolescent mental health programs must be designed to increase the number of paraprofessionals, professionals, and applicants who come from and aim to serve in underserved areas. Their curriculum for such training must be taught collaboratively to ensure coverage of the relationships between family, consumer, and behavioral health worker (PPACA, 2010). The end result of these criterion are in alignment with the PPACA's efforts to enhance mental health coverage, access, and quality for patients.

Moreover, these criterion themselves signify that there exists a growing federal awareness of and attention to workforce shortages and training issues, which lie upstream of problems that mental health care patients may face. Federal recognition and admission of workforce shortages in behavioral health education and practice are the first step towards reversing these shortages, which Section 5306 attempts to do through federal grant funds for mental and behavioral health institutions and programs

that fulfill the aforementioned sets of criterion. Approved social work programs are authorized to receive appropriations totaling $8 million from 2010 to 2013. For psychology-related programs, at least $10 million will be allocated for doctoral, postdoctoral, and internship training, with no more than $12 million to be appropriated between 2010 and 2013. Finally, approved child and adolescent mental health programs are authorized to receive $10 million for professional and $5 million for child and adolescent mental health training from 2010 to 2013 (PPACA, 2010). Here, the relative breakdown of appropriations also provides some clues as to how valuable or how deprived the federal government perceives various behavioral health programs to be. Child and adolescent mental health training receives the highest grant authorization - $15 million cumulatively – and is thus a priority over psychology-related training, which can only receive between $10 and $12 million, and social work programs, which is even further limited to $8 million in appropriations. It is not clear how policymakers researched and established this apportionment, though the main question remains whether these apportioned amounts will even be sufficient to begin producing a high-quality behavioral health workforce before the scheduled end to appropriations in 2013.

Putting these questions aside for the moment, the PPACA also attempts to enhance healthcare workforce education and training in Section 5315, which establishes the "United States Public Health Services Track" through an addendum to Title II of the PHSA. The Track program will be located in accredited, pre-existing academic health centers that are deemed appropriate by the workforce commission that was established in Section 5101, and will bestow advanced health-related degrees for emphasizing public health, epidemiology, team-based service, and emergency preparedness and response. The Track must graduate at least 50 to 250 designated health professionals annually, depending on the area of study and the prescription of the Secretary of the Department of Health and Human Services. Pharmacy student graduates lie at the low end, nursing students at the high end, and mental and behavioral health professional graduates in the middle, with no less than 100 students to be

graduated annually under the Track system. It should be noted that the dental, physician assistant, nurse practitioner, and public health students must also be graduated at a rate of no less than 100 per year (PPACA, 2010). If these numbers are to be taken as an indicator of how policymakers prioritize various health professional graduates, the PPACA equates the value of mental and behavioral health to dentists, physician assistants, nurse practitioners, and public health workers. By the same token, the national need for more graduates of mental and behavioral health professions may be perceived by policymakers as being larger than the need for pharmacy graduates and lesser than for medical and nursing student graduates. These perceptions do not necessarily contribute to an accurate portrayal of the true behavioral health needs in the U.S. and, on the contrary, may negatively impact policy decisions, grant approvals, and sustained progress in the behavioral health workforce and field in the future.

However, in theory, Section 5315 is beneficial to ensuring more integrated education, training, and practice among emerging health professionals behavioral health workers. The Track system fosters greater continuity, as it is designed to provide a longitudinal plan that emphasizes patient-centered techniques, interdisciplinary training, care coordination skills, and familiarity with emergency medical response deployment and activity. By design, the Track also encourages a shift towards decentralization of faculty development programs into different venues for healthcare. This latter provision is an effort of the PPACA to expand and balance access to education across urban, tertiary, and inpatient facilities. Overseeing the Track system is DHHS, which appropriates funds, and the Surgeon General, who administers Track functions under advisement from the Workforce Commission. Section 5315 affords the Surgeon General – or Surgeon General-approved scientists, medical, dental, and nursing professionals – the power to negotiate with the federal government, nonprofit entities, and accredited health education and training institutions in order to appropriate existing medical resources on a reimbursable basis, develop grants, and establish affiliation agreements for payment provisions for

educational services provided in the Track. Of the postdoctoral, postgraduate, continuing, and technological education programs provided, the Track system establishes cooperative programs for integrated education among mental and behavioral health, medical, physician assistant, dental, pharmacy, public health, and nursing students, with priority given to those who are underrepresented minorities or who are from rural areas. Students in the Track system are given tuition and stipends annually, for no more than 4 years. In exchange, Track students are locked into Track enrollment for the duration of their program of study, are subject to residencies or specialty internships approved by the Surgeon General, and are contracted to a period of obligated service in which they must serve 2 years on the Commissioned Corps of the Public Health Service for each school year enrolled in a Track program (PPACA, 2010).

Despite some of the contractual obligations that Track students must make in exchange for its financial benefits and training opportunities, the Track system need not be viewed as a limitation and is actually an important part of the PPACA for mental and behavioral health professionals for a number of reasons. Firstly, Section 5315 provides opportunities for interdisciplinary hospital- and community-based training in federal medical facilities in health professional shortage areas during the third and fourth years of Track enrollment. The actual period of obligated service can be reduced through participation in a high-needs specialty residency, as determined by the Workforce Commission, and by choosing to practice in a federal medical facility located in an area suffering from health professional shortages (PPACA, 2010). These incentives, as well as assigning priority to rural or minority students for Track enrollment, aim to address and redress regional and racial disparities in the scope and composition of the current behavioral health workforce. Furthermore, the cooperative program may be representative of a broadening view of mental and behavioral health care, as its focus is not to improve mental and behavioral health education and training independently from all other types of health professionals. Rather, the provision for cooperative programming is to some degree a realization that mental and

physical health needs are codependent agents for overall health and wellbeing. In that sense, this provision is an acknowledgement that there remains a large need for greater integration in the way health is approached, not just at the delivery end downstream but also at the education and training end upstream. It is therefore not in focused enhancement efforts for mental and behavioral health but in the more general push towards general integration in which lies part of the significance of the Track system.

Under Section 5315, the Track system puts additional emphasis on integrating and expanding professional opportunities by specifying that training for mental and behavioral health students – as well as for dentist, physician assistant, pharmacist, public health, and nursing students – must be comparable to that received by traditional medical students. Institutions that train all such professionals together for a significant amount of time or who have at the very least established a shared core curriculum to encourage interdisciplinary learning and practice have priority for Track funding and provisions. Additionally, the Track system makes available the opportunity to be appointed to serve on elite federal disaster teams. Highly qualified Track faculty, students, and graduates, including those focusing on the mental and behavioral health field, are rewarded for their exemplary performance in the Track system and are extended the privilege of training for and responding to natural disasters, bioterrorism events, and other public health emergencies (PPACA, 2010). Taken as a whole then, Section 5315 encourages and incentivizes more equitable interdisciplinary teaching and teamwork. Its Track system offers enrolled students the unique opportunity to receive more comprehensive training than might otherwise be provided in non-Track institutions. This opportunity is not only made available to mental and behavioral health professional students but is made available in a manner that encourages greater mental health parity and interdisciplinary cooperation. Furthermore, demonstrated success at integrative learning and training is recognized professionally through participation on an elite federal interdisciplinary team. Section 3515 therefore attempts to make parity sustainable while simultaneously

creating new professional opportunities for mental and behavioral health workers in the future – provided, of course, that an appropriate amount of funds is made available.

Teaching capacity is also an issue that must be addressed, and Section 5508 attempts to do so by increasing and enhancing training at teaching health centers. Section 5508 amends Title VII, Part C of the PHSA and inserts a provision for development grants at teaching health centers. Community mental health centers, for the purpose of Section 5508, are included in the definition of a teaching health center. Grants for these programs are intended for establishing new accredited primary care programs or for expanding current ones, where 'primary care residency programs' are defined as being those for approved graduate medical residency training in various areas of medicine. Interestingly though, psychiatry is approved as one such primary care residency program by the PPACA (PPACA, 2010). The study of psychiatry has not always been included within the realm of primary care, and primary care itself has been defined differently since the term's initial introduction into the medical lexicon in 1961. The Institute of Medicine [IOM], for example, defined primary care in relatively general terms 15 years ago, although it also conceded that some legislation has defined primary care to include other specialized fields such as pediatrics, obstetrics and gynecology, nurse practitioners, and physician assistants (Institute of Medicine, 1996). Even today, national organizations tend to uphold a more general definition of primary care, and do not typically or explicitly include psychiatry as a part of primary care (American Academy of Family Physicians [AAFP], 2011). As such, the classification of psychiatry under the category of primary care in Section 5508 suggests psychiatry has been approved as a valuable field of graduate medical residency, and it contributes to and impacts other areas of medicine that have traditionally fallen under the umbrella of primary care, to a degree that psychiatry should be similarly categorized today.

Section 5508 also amends Title III, Part D of the PHSA in an effort to address payment mechanisms to support graduate medical education – and approved residency programs like psychiatry

– at qualified teaching health centers. The added Subpart XI establishes a program of payments to cover both direct and indirect expenses, not to exceed a total of $230,000,000 from 2010 through 2015. The exact proportion of funding for direct educational expenses is based on an updated formula for national per-resident amounts, while funding for indirect educational expenses must take into consideration all other secondary training costs associated with primary care residency programs. These payments are to be made in addition to previously legislated or awarded funding for graduate medical education, and are therefore not meant to replace but rather provide additional economic support for qualified teaching health centers to meet the demands of an expanded workforce outlined previously in Section 5508. The final component is annual reporting, which must detail the types of approved primary care training provided for full- or part-time residents, the number of approved resident training positions, and the number who completed their training and went on to work for vulnerable populations or in underserved areas. This final provision ensures that approved qualified teaching health centers are providing graduate medical education training and programs that are in line with the objectives of Title V of the PPACA. Future audits and funding limitations are likewise informed by the accuracy and completeness of these reports. Regulations, however, are undefined in this section, perhaps because this legislation is at too early a stage to determine or predict what regulations and safeguards might be needed in the future. One anticipated issue lies in how effective annual self-reporting will be, despite its ties to federal funding. It is conceivable that institutions may find ways to bend annual reporting guidelines to receive federal funding regardless of actual performance.

Finally, in another effort to integrate physical and behavioral health services, Title V of the PPACA introduces Section 5604, which amends Title V, Part B, Subpart 3 of the PHSA to award grants and cooperative agreements for eligible community mental health centers that co-locate primary and specialty care in their facilities. A total of $50,000,000 is appropriated to section 5604 in fiscal year 2010, with amounts for 2011 through 2014 to be determined in the future. To be eligible, centers must

establish demonstration projects that have partnerships or arrangements with local primary care providers, to provide primary and specialty care services in a co-located, coordinated, and integrated manner. The recipients of these services are termed “special populations,” whom Section 5604 defines as being adults with mental illnesses who have co-occurring chronic diseases and primary care conditions. Once awarded, grants may then be used towards on-site primary care service provision, on-site referral-related costs, information technologies, and facility modifications to accommodate the clinical needs of primary and specialty care professionals. Within 90 days of a grant or cooperative agreement expiring, community mental health centers are also required to submit a self-assessment evaluating the effectiveness of those activities or services (PPACA, 2010). However, Section 5604 may face the same problem that threatens Section 5508 – that is, self-evaluation is only as thorough, effective, and accurate as the institution in question intends. Unregulated self-reporting exposes PPACA provisions to inefficient execution and may weaken accountability. Just as Section 5508 does not create an independent group to back-check that approved qualified teaching health centers are providing appropriate graduate medical education training and programs, Section 5604 does not create an independent commission or entity for the purpose of confirming self-evaluations submitted by community mental health centers. The real danger with Section 5604 then, and similarly with Section 5508, lies not with provisions that are made but with those provisions that are not made.

Title V ends with Section 5604, but mental health provisions may still be found in the latter half of the PPACA, albeit these provisions are much fewer in number and not of central focus; indeed, Title VI only sees one mention of mental health, in Section 6703, which deals with elder justice. Section 6703 is alternatively known as the Elder Justice Act of 2009, an amendment to Title XX of the SSA that prevents, detects, and treats issues of abuse, neglect, and exploitation of the elderly by caregivers or other individuals and entities with a fiduciary responsibility for the elderly. Here, mental health is mentioned only within the context of self-neglect, in the sense that Section 6703 affords some protection for

elderly individuals who are physically or mentally incapable of obtaining goods and services to maintain their own mental health. Mental health protection is therefore a necessary component of overall wellness and is extended to the elderly as a criterion for social justice, although mental health is specifically framed in terms of elder neglect, and is written as such in Section 6703. The new Elder Justice Coordinating Council, for example, coordinates various federal, state, local, and private agencies and services that prevent elder neglect. The Advisory Board on Elder Abuse, Neglect, and Exploitation devises interdisciplinary strategic plans that inform the Coordinating Council and promote awareness of elder neglect. Section 6703 also establishes human subject protections to prevent elder neglect in research, facilitates reporting of unlawful elder neglect, and provides grants for elder forensic centers to develop forensic research and services related to elder neglect. Finally, Section 6703 provides grants for elderly protective services and for staff retention and ombudsman programs against elder neglect in community-based care facilities (PPACA, 2010) which, although not explicitly mentioned, may be interpreted to include long-term community mental health centers. Unfortunately, beyond self-neglect, mental health issues appear to be of minimal concern in elder justice, despite their importance to overall health and wellness.

Following Section 6703, there is no mention of mental health in Titles VII, VIII, and IX; efforts to improve mental health are only revisited in Title X, which attempts to strengthen the quality of affordable healthcare. Even then, mental health plays a small role in reform efforts, appearing only twice in Title X beginning with Section 10334. Section 10334 calls for the creation of an Office of Minority Health within the Office of the Secretary of DHHS. The Office of Minority Health's general aims are to enhance and evaluate the quality and cultural competency of minority health care through cooperative, interagency agreements and partnerships with organizations linked to ethnic and minority communities. In support of these objectives, Section 10334 amends Title XVII of the PHSA to establish individual offices of minority health within the DHHS, specifically in the Health Resources and Services

Administration [HRSA], the Agency for Healthcare Research and Quality, the Food and Drug Administration [FDA], CMS, CDC, and – most importantly for mental health professionals – SAMHSA. Agency-specific offices of minority health are not subject to dissolution or termination through an Act of Congress, but it should be noted that allocations for the creation of such offices are specified by the Secretary of DHHS to be taken from other agency programs (PPACA, 2010). Because no additional funding will be granted to establish or staff agency offices of minority health, these new offices will actually divert funds from pre-established programs. Thus, while Section 10334 may reduce ethnic and racial disparities within and specific to a DHHS agency's goals, the very act of creating an additional office within SAMHSA may rob the agency of resources for other mental health programs and services, none of which are to be considered less important or less problematic than racial and ethnic mental health disparities at present.

Mental health plays one last, significant role in Title X, Section 10410, also known as the Establishing a Network of Health-Advancing National Centers of Excellence for Depression [ENHANCED] Act of 2009. Section 10410 establishes national Centers of Excellence for Depression through an amendment to Title V, part B, subpart 3 of the PHSA. These Centers focus on depressive disorder specifically, which the PPACA defines as a mental or brain disorder that is linked to such depression as major depression, bipolar disorder, and similar mood disorders. Competitive 5-year grants will be provided to eligible entities – institutes of higher education, and public and private nonprofit research institutions – that provide or coordinate comprehensive health services that focus on mental health professional training, depressive disorders, and co-occurring mental illnesses. Federal grant amounts must be matched by each Center at a rate of $1 of non-federal funding per $5 of federal funding. Grant funds must additionally be used to facilitate treatment activities for depressive disorders. No more than 30 Centers are to be established by September 30, 2016, and grants may be renewed once, depending on an entity's report card performance. Of course, priority is given to grant awards under certain

circumstances. For example, entities operating in medically underserved areas, areas with health professional shortages, or areas with populations at high risk for depressive disorders. Entities that have already modernized their practices, have demonstrated the ability to collaborate with community mental health centers, and have already developed culturally-competent and evidence-based expertise and infrastructures will also be given priority access to grants (PPACA, 2010). Giving priority to facilities that already have relatively well-developed programs and services may not be the most effective use of funds though, as less developed entities may have a greater need for enhancement grants. In the interest of more comprehensive improvements for mental health programs, then, there is currently a bias against less updated mental health facilities, in the way that enhancement grants are prioritized and awarded by Section 10410.

Among the Centers created through Section 10410 provisions, one shall be designated as the National Coordinating Center to coordinate the entire network of Centers and to oversee a national database that consolidates and disseminates the activities conducted at these Centers. Each Center will, in turn, develop a research agenda regarding the implementation of interdisciplinary, evidence-based practices and interventions for depressive disorders. In doing so, Centers must provide training and technical support to mental health professionals, and must educate policymakers, employers, community leaders, and the general public to increase the awareness of and decrease the stigma that is presently attached to depressive disorders. Another goal for Centers is to collaboratively improve the standards, clinical guidelines, and protocols for depressive disorder diagnoses and treatments, in a way that emphasizes primary prevention, early intervention, and interdisciplinary approaches for treating co-occurring physical and mental health conditions. Such approaches leverage community resources, integrate self-management programs, and involve a large network of familial and community social support in each care plan (PPACA, 2010). These steps represent a national attempt to increase awareness and decrease stigma of depressive disorders, particularly as they are linked to concurrent

physical health conditions and other mental health issues such as substance abuse disorder. Likewise, Section 10410's provisions for interdisciplinary cooperation and community-based care plans are indicative of efforts to better integrate physical with mental health, and are a commendable start to more comprehensive health care overall.

In addition to working with individual Centers, the Coordinating Center plays other key roles as well. One function of the Coordinating Center is to act as a liaison to various federal interagencies, administrative offices, and other mental health-related forums. The Coordinating Center is also expected to manage and improve access to depressive disorder care through electronic health records, telehealth technologies, ongoing professional and education opportunities for mental health professionals, and translational research (PPACA, 2010). Translational research embodies the process of translating basic scientific research into practical applications in a clinical setting, and has proven to be successful in driving further clinical research. The success of translational research derives from a cyclic feedback loop, in which clinicians use scientific research-derived tools on patients and assess their impact on disease progression, which then informs and encourages future avenues of scientific and clinical research (The NIH Common Fund, 2011). Translational research, as a key component of the Coordinating Center's responsibilities, is relevant to overarching efforts in the PPACA to develop and expand patient-oriented research and treatments, and is also expected to play a role in enhancing the publicly accessible national database, which the Coordinating Center also oversees. This database will compile data from each Center on the prevalence, incidence, health and social outcomes of depressive disorders, as well as the effectiveness of related treatments. Collectively, these provisions strive to improve depressive disorder prevention and management programs, and evidence-based interventions (PPACA, 2010).

Moreover, Section 10410 provides one more measure of evaluating depressive disorder care plans and treatment programs using a report card system based on standards established by the

Secretary of DHHS for all Centers, both as individual entities and as a network. Within 3 years of receiving the title of Center of Excellence and annually thereafter, the performance of each Center will be scrutinized in report cards issued to the Coordinating Center. Following that same time table, Congress will also be issued report cards and will have the opportunity to rate the performance of the network of Centers as a whole. By September 30, 2015, the Secretary of DHHS will make recommendations based on these report cards, regarding improvements specific to each Center or expansions in the system of Centers to serve additional types of mental disorders. Additionally, Section 10410 installs an independent, third-party review system to double-check the efficacy of the network of centers. In order to accomplish these lofty goals, $100,000,000 is authorized to be appropriated annually from 2010 through 2015, and $150,000,000 from 2016 to 2020. The Coordinating Center may receive up to $10,000,000 of those funds annually, while standard Centers will not be allocated more than $5,000,000 (PPACA, 2010).

The quantity of allocations is relatively high, and indicates a respectable level of federal commitment towards developing a comprehensive depressive disorder care and support network. However, it is notable that the provision does not create or require individual Centers to undergo an independent third-party review, similar to that required of the overall network. The performance and success of the overall network of Centers is an aggregate of the performance of each individual Center. Like many provisions before it, those in Section 10410 fail to fully ensure accurate and reliable performance reporting, and do not go far enough in back-checking evaluations or sustaining improvements to the current system of mental health care. Still, Section 10410 does present provisions that are specific to a mental illness – depression – and although such a focused directive is not delivered until the final 50 pages of the health reform bill, provisions for a mental condition as specific as depressive disorders are delivered nonetheless.

DISCUSSION

This CBMP was a multifaceted project which attempted to approach one specific aim – analyzing the impact of the PPACA on behavioral health – through five unique but not altogether unrelated lenses – the "who," the "what," the "how," the "where," and the "when" of mental and behavioral health provisions, as written in the PPACA. Through the course of this study, 25 sections of the PPACA were found to contain behavioral health-related provisions, but not all 25 sections were afforded the same degree of importance, as was inferred by differing levels of political involvement and economic appropriations for behavioral health versus non-behavioral health provisions. At the same time however, there is also evidence that the PPACA will have some lasting impact on behavioral health in terms of "who," "what," "how," "where," and "when." Some of the PPACA's larger or more reaching behavioral health provisions are listed below – although indeed, much change in the past has arisen out of incremental policy change, and attention should thus be paid to even the smallest or least reaching behavioral health provisions in the PPACA.

"Who"

The first focal point for this study's specific aim addressed the "who" of behavioral health – that is, those individuals or institutions that are to provide behavioral health services in the future, as determined by the PPACA. Stemming from the early days of the U.S. health system, behavioral health services were initially provided by public sector workers, from local to state government workers and institutions. Today, due to various payment structures and policy changes, behavioral health service providers include psychologists, social workers, counselors (Gray, Brody, & Johnson, 2005), and primary care physicians, the last of whom are arguably the least prepared class of professionals to prevent, diagnose, and treat mental and behavioral health illnesses. Simultaneously, there exists limited availability and an overall shortage of behavioral health professionals for consultations and appointments (RAND, 2009),

due in part to misalignment in reimbursements and financial incentives, as well as a general lack of parity and mental health care support from political forces nationwide (Goodson, 2010).

In answer to the question of "who," the PPACA addresses behavioral health provider-related issues in Sections 2703, 2707, 3502, 4001, 5002, 5101, 5203, and 5306. While these sections are cumulatively important for building a more sustainable behavioral health system overall, Title V provisions such as Section 5002, 5101, and 5203 are of particular note, as they best pertain to and clarify the "who" of behavioral health, both in relation to other health professionals as well as in terms of more specific education and training experiences:

- "Health professionals" now broadly includes psychologists, social workers, substance abuse prevention and treatment providers, and other mental health professionals, and the "health care workforce" is now explicitly inclusive of mental health professionals.
- "Mental health service professional" is defined to include graduates of accredited institutions of psychiatry, psychology, behavioral pediatrics, psychiatric nursing, social work, and school counseling.
- "Graduate psychology" is recognized as a valid field of behavioral health training.
- A "qualified medical professional" for child and adolescent mental health care is one who has clinical experience or has completed specialized training in psychiatry, psychology, school psychology, social work, school social work, behavioral pediatrics, psychiatric nursing, marriage and family therapy, school or professional counseling, and substance abuse prevention and treatment.
- "Paraprofessional child and adolescent mental health workers," while not explicitly defined as mental health service professionals, are nonetheless recognized as being the first point-of-contact for individuals seeking mental health care services.

These Title V provisions are significant in two ways: first, they provide some clarity – be it explicit or implicit – on the current definition and roles of various behavioral health providers, and second, they reinforce the notion that behavioral health providers will not differ much in the future from who they are today. The PPACA's redefinitions of behavioral health professionals do not reclassify behavioral health workers from the past so much as they outline those educational and training credentials that behavioral health providers must embody today. These credentials, and consequently the roles that behavioral health providers play under the PPACA, remain relatively unchanged from those at present. The implication is that behavioral health providers in the future will continue to be those same individuals who are providers today – namely accredited psychiatrists, psychiatric nurses, psychologists, behavioral pediatricians, social workers, and school counselors. The future "who" of behavioral health care then, as dictated by the PPACA, does not depart significantly from that of the past. On its own, this constancy in behavioral health providers over time does not appear to pose any overt problems for the provision of behavioral health care. However, when considering expansions to and changed definitions for "what" of behavioral health entails, the static nature of the "who" of behavioral health represents a limitation, an inability to adapt to both historic shortfalls and to changes in the larger healthcare system at present, that the field of behavioral health has yet to overcome.

"What"

The next facet of this study was the "what" of behavioral health – that is, the exact definition of mental and behavioral health care, conditions, and services. Recall that, historically, such definitions have fluctuated depending on public policies and their manner of addressing the scope and severity of mental and behavioral health conditions. Definitions of behavioral health have tended to adopt one of two perspectives: narrow and broad. Broad definitions take into consideration social, cultural, psychological, and medical factors that contribute to mental and behavioral disease etiology. The broad perspective has been used in numerous past policies, and today describes behavioral health in categorical, social,

and economic terms. The narrow perspective, on the other hand, typically returns to prominence when, as was the case in the late 1980s, specific chronic and severe behavioral health issues demand a more targeted focus (Goldman & Grob, 2006).

This study adopted a broad stance towards behavioral health, which viewed behavioral health as an inseparable and integral component of overall health and wellness. As such, prevention, intervention, and research must play significant roles in the system of behavioral health care and delivery (Smith et al., 2002). This study sought to find evidence of a similar approach in writings of the PPACA, and just as policies have shaped definitions and perceptions of behavioral health in the past, so too does the PPACA impart new meaning and therefore new modes of thinking about the way in which the behavioral health system will be defined in the future. Although these new definitions for various components of the behavioral health system do not necessarily dictate a solution for existing problems within that system, the PPACA does redefine certain elements of the behavioral health system in Sections 1302, 1311, 2001, 2952, 4101, 5002, 5508, 5604, 6703, and 10410.

Among the provisions that address the "what" of behavioral health, there is evidence of a broad framework in the PPACA's efforts to encourage research, prevention, and intervention; however, it is actually those provisions that utilize a more narrow framework – provisions as found in Sections 1302 and 1311, specifically – which hold the most significance for the field itself. Sections 1302 and 1311 have perhaps the most impact on the field because they redefine behavioral health in a way that allows insurance coverage and benefits to be extended to behavioral health services. Whereas previously behavioral health coverage was considered supplemental, or "non-essential," under the PPACA mental health services are explicitly defined as "Essential Health Benefits." The degree of mental health coverage and benefits must match that of medical and surgical coverage for such items as lifetime and annual coverage limits, financial requirements for coverage, treatment and care limitations, availability of coverage information, and employee and cost exemption determinations. The significance is that

basic insurance coverage for behavioral health services will not only be available but must also be provided at the same level and extent as that for medical and surgical services. The PPACA then redefines behavioral health services narrowly at the insurer level, in an attempt to expand parity for behavioral health services at the patient level. Of course, true parity can only come to fruition so long as insurers and the general public abide by the PPACA's new classification of behavioral health as an "essential" benefit, thus it is critically important that the PPACA has redefined and has made provisions for behavioral health services to be treated as such, in Sections 1302, 1311, and beyond.

"How"

The aforementioned "who" and "what" of behavioral health help inform the "how" – that is, the mechanisms of financing and reimbursing for behavioral health-related services and provisions. Historically, the behavioral health system has failed to provide satisfactory coverage for patients with mental illnesses. Prior to the 1980s, behavioral health programs were funded categorically by grant-based programs, which rarely passed Congressional approval for renewal, and therefore could not reimburse or finance high-quality behavioral health programs in a sustainable manner. Managed care organizations exacerbated the problem by carving out behavioral health from the rest of medical science, which has caused participating providers to push behavioral health patients into primary care, and has led to increased costs of care, fragmentation, and system inefficiency (Gray et al., 2005). Medicare and Medicaid eventually became the backbone of financing behavioral health services publicly, although some payment limitations remain (Goldman & Grob, 2006).

This third facet of this study sought to find evidence that the PPACA addresses some of these shortfalls in the current system of financing and reimbursing for behavioral health care. Examples of such evidence included a greater focus on integrating payment methodologies, or essentially carving behavioral health care back into the health care system at large. Unfortunately, no significant provisions for carve-in strategies were found. Other efforts included greater parity in payment and reimbursement.

Payment and reimbursement parity could be shown by fair and equitable amounts being charged for behavioral health services and medical care coverage, fair and equitable costs for patients with chronic and severe mental health conditions relative to those who are in perfect mental health, and subsidized payments for disadvantaged and underserved patients relative to those who are well-off. Fortunately, some of these changes were evidenced in the PPACA.

Indeed, the PPACA did appear to make some minor efforts to correct historic shortfalls and disparities in the "how" of behavioral health care. Of the 25 sections of the PPACA that contained behavioral health-related provisions, 16 addressed payment and reimbursement structures, or made mention of a financing system for behavioral health institutions, providers, and services. These were Sections 1302, 1311, 2703, 2707, 2952, 3107, 3502, 4004, 4101, 4201, 5203, 5301, 5306, 5508, 5604, 10410. The remaining 9 sections of the PPACA contained behavioral health provisions, but either did not provide a funding mechanism, or the role that behavioral health played in the provision itself was so minor that no reimbursement structure or system was warranted. As these 9 sections indicate, then, there remains an inconsistent and often blatant absence of funding for behavioral health services in the PPACA, despite attempts to increase overall parity for behavioral health; in this sense, the PPACA fails to fully extend parity for behavioral health, at least in terms of funding and reimbursement systems.

As for the 16 sections that did offer economic recourse or include a financing mechanism, federal funding is used in a rather broad manner that tackles a wide range of topics including patient and provider reimbursement, workforce development, research, outreach, prevention, and integration. Unfortunately, these provisions use the categorical funding model put in place in the 1980s. Under this model, grant-funded provisions may prove difficult to renew and may not be ideal for long-term, sustainable use to reimburse or finance high-quality behavioral health programs of a broad nature. Of course, the PPACA does make some more narrowly focused changes towards behavioral health payment structures. Section 3107, for example, alters Medicare physician fee schedules and extends them to

cover mental health. These changes do not affect the types of mental health services covered, but rather the payment scheme itself. On a deeper level, Section 3017 is perhaps even more significant because its provisions address the insufficiency of current payment schemes to meet both patient health needs and physician reimbursement demands, and demonstrates federal recognition of this problem. The implication is that narrow changes to behavioral health payment structures – such as those outlined in Section 3107 – might eventually bring about broader changes in reimbursement, as they have done so in the past. Thus, even narrow changes may prove extremely significant in terms of answering the "how" of behavioral health in the future.

"Where"

The fourth critical focal point of this study concerns the "where" of behavioral health – that is, the physical sites or locations for behavioral health service delivery following enactment of the PPACA. Like the aforementioned questions, "where" behavioral health services are delivered has changed significantly over time. Also, partly as a function of changes in provider type, behavioral health definition, and payment structure, the actual sites for behavioral health services have historically been distinct from sites for general health services. In the early part of the 20th century, behavioral health care sites tended to be almshouses and state institutions. In the second half of the 20th century, important sites for behavioral health care delivery included community mental health centers, state hospitals (Goldman & Grob, 2006), and other solo practitioner, primary care, community, and integrated care settings. Unfortunately however, this physically fragmented system of delivery is plagued by uncertainty in quality and disparities in access of care (Gray et al., 2005). This study therefore sought to investigate whether the PPACA addresses these issues or even simply clarifies where behavioral health services will be provided in the future.

Sections 2703, 2707, 3502, 4101, 4201, 5301, 5508, 5604, and 6703 were found to discuss sites of future behavioral health service delivery, and in general, the PPACA indicates that many of the sites in

which behavioral health services are provided today will continue to be sites for future service delivery. However, the PPACA does begin to co-locate behavioral health services in primary care settings, and does provide support for a "health home" or patient-centered medical home model of care, in which care services are closely tailored to an individual patient's needs and circumstances, and are even provided in the home environment if necessary. These notable innovations in service sites may be found in Sections 2703, 3502, and 5604:

- Section 2703 establishes state options to provide "health homes" for Medicaid enrollees with chronic conditions. These health homes are coordinated models of care open to Medicaid enrollees with chronic physical and/or mental health conditions who also require home services.
- Section 3502 establishes interdisciplinary community health teams whose mission is to develop and support patient-centered models of care. This model aims to provide focused care services that is tailored and personalized to a particular patient's circumstances and needs.
- Section 5604 establishes demonstration projects to co-locate primary and specialty care services in community-based mental health settings. As demonstration projects, these settings may not produce elevated health outcomes immediately at their outset. However, co-located care settings represent one step towards a more integrated health care system overall, and are significant in this fact.

It is further important to note that the "where" of behavioral health is highly dependent upon the "who," "what," and "how" of behavioral health – and vice versa. The PPACA changes mental health provider and disease definitions as well as payment and insurance policies, all of which implicate treatment at one type of site versus another. The PPACA's push towards a more personalized, integrated, patient-conscious care delivery is an admirable response to historic shortfalls in behavioral

health care delivery due to fragmentation. Though not all behavioral-health related provisions discussed care sites, the smaller-scale changes as offered by Sections 2703, 3502, and 5604 represent a significant departure from how care sites have been depicted in the past, and are therefore highly significant for their potential to effect broader improvements to behavioral health service sites in the future.

"When"

Finally, the "who," "what," "how," and "where" of behavioral health are meaningless without knowing the "when" – that is, the general timeline during which significant PPACA provisions for behavioral health are in effect. It cannot be emphasized enough that behavioral health provisions, as written in the PPACA, are the result of a long history of different policies over time, stakeholder interest, and ongoing shortfalls in the behavioral health system. Just as past policies have altered the course of this nation's health system, so too will the PPACA have both short- and long-term impacts on behavioral health, with several important provisions taking effect in 2010 through 2013, 2015, and beyond.

Behavioral health-related provisions in the PPACA have been in place as early as 2010, following fast on the heels of the bill's passage. As of this study's completion, several provisions have already taken effect to enhance behavioral health coverage, encourage more integrated models of behavioral health care, and increase funding for education and training of behavioral health professionals:

- Sections 1302 and 1311, effective as of 2010, set the grounds for remodeling the entire structure of behavioral health insurance, by including mental health coverage as an "essential health benefit."
- Section 4011, effective as of 2010, forms a National Prevention, Health Promotion, and Public Health Council in order to modernize and integrate health care in the U.S., essentially paving the way for policymakers to reunite various fragmented health systems across the nation today.

- Section 5306, effective through 2013, recognizes shortages of behavioral health professionals and issues education and training grants to support recruitment and development of the upcoming behavioral health workforce.

Notably, many of the PPACA's provisions regarding behavioral health education and training end in 2013. However, in order to develop a high-quality, well-prepared behavioral health workforce, these provisions would not only need to begin as soon as possible but also continue to be in effect throughout the entire duration of the PPACA. Instead, the active period for such Title V provisions seems to terminate prematurely, causing some concern over durability of, sustainability of, and eventual emergence of gaps in workforce development. These gaps would expose a troubling shortfall in the scheduled timeline of behavioral health provisions, and might in the future act as barriers to successful implementation of the PPACA. Nevertheless, overall efforts to improve various facets of the behavioral health system in general are set to continue through the PPACA's effective timeline, and at the very least should conclude with the addition of 24 million newly insured individuals for whom the behavioral health system must also attempt to provide care, by 2019.

Trends and Limitations

Following this study's analysis of the "who," "what," "how," "where," and "when" of behavioral health, it became evident that, despite the PPACA's efforts to improve upon the current behavioral health system, both positive trends and negative limitations exist in several provisions.

Among the 25 sections containing behavioral health-related provisions in the PPACA, some key trends were found to be recurrent (Appendix D):

- Greater emphasis on integration, coordination, and interdisciplinary cooperation.
- Greater emphasis on research and cost-effective preventions.
- Greater emphasis on culturally-appropriate care for at-risk, vulnerable, and underserved populations.

- Large investment in workforce development, training, and educational enhancement.
- Modest attempts to ensure parity for behavioral health.

First, there is a general push towards greater integration, coordination, and interdisciplinary cooperation, as seen in the PPACA's efforts to encourage interagency support and team building, health homes, and evidence-based, patient-centered models of care. Second, behavioral health-related provisions in the PPACA place a greater emphasis on research into serious mental illnesses, cost-effective preventions, and culturally-appropriate care for vulnerable and underserved populations, including children, mothers, Medicaid patients, ethnic minorities, and the elderly. Additionally, workforce development and enhancement comprises a large portion of behavioral health-related provisions, with the PPACA issuing several education and training grants, and creating an academic track to promote higher learning in accredited health centers. Finally, there is a push towards greater mental health parity – not only in terms of care provision and descriptive definitions of behavioral health, but in payment as well.

The issue of parity is a major one, and efforts to improve parity for mental health have been long overdue. Among all behavioral health-related provisions in the PPACA, Sections 1302 and 1311 are perhaps most significant in that they represent steps towards greater mental health parity in coverage. Historically, parity has been sorely lacking, with most mental health conditions and treatments completely lacking coverage, and only very few that even had coverage, albeit of a lesser nature than that provided for medical and surgical services (Health Services Research Center, 2010). The PPACA dictates that coverage for behavioral health care and treatment must meet that of standard medical and surgical care. In other words, deductibles, copayments, visits to health professionals, and out-of-network care benefits cannot be more restrictive for mental illnesses than for medical and surgical care. By extension then, substance use disorders and mental health illnesses also must receive the same degree of coverage as standard medical illnesses, like cancer, diabetes, and heart disease.

As of September 23, 2010, immediate changes following the passage of the PPACA extended these new benefits to the behavioral health system. Today, there can technically be no denial of mental health coverage for pre-existing conditions in individuals below the age of 19, no lifetime limits on mental health coverage for existing plans, and no annual limits on mental health coverage for new plans. Likewise, new family plans must offer mental health coverage for dependents up to age 26 (Mannino, 2010). Finally, and perhaps most importantly for patients, parity under the PPACA now includes payment for mental health services, which is unfortunately one of the first provisions at risk of retraction, should future political forces vote to repeal the PPACA (Liu, 2011).

Unfortunately, in addition to external opposition to the PPACA, behavioral health-related provisions within the PPACA are themselves limited by several policy problems that inherently bar full parity (Appendix E):

- Lack of third-party, independent review system for new program initiatives.
- Lack of behavioral health input in new interdisciplinary initiatives.
- Vague, unspecified, disparate, or nonexistent monetary amounts for appropriations.

First, there is often a lack of third-party, independent review system for program evaluations established by the PPACA. This issue applies mostly to Title V workforce provisions but nonetheless leaves the system without a way of consistently and objectively ensuring the quality and success of new or modified behavioral health initiatives. Secondly, and even more problematic for establishing parity, newly formed commissions may lack a behavioral health viewpoint; while feedback from other professional fields is mandatory, involvement from behavioral health professionals on interdisciplinary teams is not required. The absence of behavioral health insight reduces the interdisciplinary nature of these team initiatives and, indeed, seems to be in conflict with other efforts by the PPACA to increase integration and decrease fragmentation in the health system. Finally, there are frequently vague, unspecified, disparate, or nonexistent monetary amounts designated for behavioral health

appropriations, compared to that for other fields. It is possible that such vagueness may reflect uncertainty in the amounts needed for new initiatives, but it is equally likely to signify that behavioral health provisions are less of a federal priority than others. In any case however, the truth is that such limitations only demonstrate a continued lack of or incomplete development of mental health parity. Despite all the PPACA's efforts to foster more equitable costs, coverage, quality, and receipt of behavioral health services, then, still much more remains to be accomplished, particularly in terms of behavioral health parity.

CONCLUSION AND RECOMMENDATIONS

In spite of the answers it provides, the PPACA only partially or not at all resolves historic issues for the field of behavioral health. In asking "who," "what," "how," "where," and "when," and in scrutinizing 906 pages and 25 sections of the PPACA, several behavioral health-related provisions were found that address providers, behavioral health definitions, financing mechanisms, and delivery sites, from 2010 through 2019. However, many attempts to encourage parity, integration, and workforce development seem haphazardly, disingenuously, or incompletely considered in the process of writing the PPACA, and as a result several provisions fall short of achieving their intended purpose. Still, regardless of its shortcomings, overall the PPACA takes steps towards reforming the mental health system (Appendix F), and in doing so, presents possible targets on which mental and behavioral health professionals and advocates may focus their efforts in the future (Appendix G).

Mental and behavioral health professionals should have a continued interest in the actual outcome of health reform. The American Psychological Association Practice Organization (APAPO), for example, has worked throughout the legislative process to ensure that the interests of psychologists will remain protected following passage and enactment of the PPACA. As a result, the PPACA makes some provisions to preserve practice and payments for psychologists practicing psychotherapeutic treatment

under Medicare. Much of this protection comes in the way of the PPACA's aforementioned general insurance market reforms which, thanks also to Section 1311's parity provisions, apply to mental health as well. Traditional psychological practices have thus been safeguarded while new opportunities have simultaneously been generated, both in private health systems and in public Medicare and Medicaid programs. Employer-based healthcare, for instance, will continue to be one platform for the provision of traditional psychological practices. However, the PPACA also generates new primary and preventive care initiatives which in general improve system integration, quality, and access, and further turn health practitioners towards a more comprehensive, patient-centered model of mental and physical health care (APA Practice Organization, 2010).

New primary and preventive care initiatives, as found in Sections 2001, 2703, 3021, 3502, 4001, 4002, and 10333 provide opportunities for practicing psychologists and other behavioral health professionals (APA Practice Organization, 2010) within the primary care field. By drawing mental health care further into the political spotlight, the PPACA actually presents policymakers and providers an opportunity to make primary care services more sustainable and to lower such treatment costs, by addressing those patients who skip their medications, delay recommended tests and procedures, and neglect their mental health care needs. True sustainability, not just for primary care but for the mental health system as well, can only be achieved through a fortified care workforce and a well-coordinated infrastructure for service provision (McDermott, 2011). In fact, the Secretary of Health and Human Services herself, Kathleen Sebelius, has been quoted as confirming the need to fill the shortage in the health workforce (Iglehart, 2011), and indeed the PPACA injects funds designed to expand primary care training pipelines and invest in integrated, interdisciplinary mental health training and education.

In addition to integrated primary and preventive care services, a well-trained, high-quality health workforce is critical to overall health system sustainability, and the PPACA extensively addresses shortages in mental and behavioral health workers in Title V. Section 5002 outlines individuals who,

under the PPACA, are recognized as being members of the behavioral health workforce, while others like Sections 5101, 5203, 5301, and 5306 describe some programmatic innovations and funding strategies for increasing and enhancing education and training for behavioral health workers. In this way, the PPACA fortifies the behavioral health system at a point upstream from patients and consumers – starting from the provider base itself – and in doing so attempts to establish a solid foundation on which to pave the way for a gradual, national move towards overall health system stability and sustainability in the future.

Overall, the PPACA will certainly have an impact on patients and consumers. On the patient's end, the extension of general insurance market reforms over mental health means that there will be greater parity in coverage rates and benefits. The expectations are that the quality and capacity of behavioral health care will improve in general, particularly through increased use of performance review, quality reporting, research, and service delivery in underserved, high-risk, minority, or multicultural areas. Patients are also expected to benefit greatly from the PPACA's shift towards a health home and evidence-based, patient-centered model of care, which will enable services to be better tailored to individual patients' needs in the future. Meanwhile, those same general market reforms that benefit patients should also benefit behavioral health providers, as they safeguard existing practices and additionally offer new opportunities for future practitioners.

New opportunities will especially exist for current professionals to work in underserved or high-risk areas, to enact positive change as instructed by newly formed interdisciplinary health commissions, and to modify education and training models to accommodate evidence-based care, patient-centered services, and quality reporting. With some $35 million earmarked towards mental and behavioral health education grants (Liu, 2011), professionals might additionally look to Sections 2952 and 4101, for example, in answering how funding will be provided under recent mental health system reform. Current or emerging mental health professionals working in underserved areas, or in areas facing barriers to

mental health care, should pay particular attention to these provisions and their future impact on behavioral health education, workforce development, and quality of care, particularly because it will take years to complete training for new behavioral health professionals and, thus, any changes in training and education must be extracted from the PPACA as quickly as possible.

Of course, much of the impact of PPACA implementation will depend on whether the reform is allowed to proceed, both nationally and state-by-state. Provisions will likely become more uniform across the nation following 2014, although individual states have some freedom to alter their own practices as they see fit. Meanwhile, Massachusetts has already implemented substantial coverage since 2006, and is virtually a model for the overarching health reform to come. Oregon has been investigating the feasibility of building a public option into its state exchange, while other states facing relatively high rates of uninsurance, such as Texas, will have less leeway to diverge from the guidelines set forth by the PPACA (Tumulty, Pickert, & Park, 2010). However, several attorneys general have already contested the constitutionality of the bill, and although no case law exists on the subject matter as of yet, 33 states have filed or are pre-filing the Freedom of Choice in Health Care Act, which opposes the PPACA's individual mandate and renders any such requirement unconstitutional (Burns, 2011). The state of Pennsylvania is among those in favor of the Freedom of Choice in Health Care Act (American Legislative Exchange Council, 2010), and had filed a suit in 2010, decrying the PPACA's unconstitutionality only shortly after its passage (Burns, 2011).

Pennsylvania's early opposition is not indicative of future political support for the PPACA, however, and while the specific point of contention may simply be the individual mandate, Pennsylvania's rejection of the PPACA could have dire consequences for the state's mental health infrastructure and ability to coordinate and integrate behavioral health services in the future. At present, it remains to be seen whether Pennsylvania will be expected to uphold the PPACA. In the meantime, efforts to fortify state and national behavioral health systems should persist, and behavioral

health providers should take active steps to improve upon the current behavioral health system in their local community:

- Network and co-locate services for primary and behavioral health care.
- Invest in education and training for culturally-competent, patient-centered care.
- Improve internal standards for workforce recruitment, quality review, and reporting.

Community mental health centers should begin networking to co-locate services for primary and behavioral health care. At the same time, teaching institutions should invest in education and training for culturally-competent care, potentially centered in health homes and utilizing a patient-centered model of care. Finally, hospitals and clinical institutions can also prepare, beginning at the leadership and management level. First and foremost, unique patient needs must be integrated into clinical policies and practices.

Nationally, all teaching, training, and clinical institutions should begin to target their workforce recruitment efforts to develop a culturally competent, even bilingual behavioral health staff, as well as a culturally-relevant system for collecting and using patient-level data for practitioners. Such a system might begin with a baseline assessment of an institution's ability to meet patient-level needs, and should follow by using aggregate patient-level data to modify programs and initiatives to meet the needs of the broader population. To ensure that each institution is meetings its patients' and target population's needs, it is additionally important to implement a reporting mechanism that invites community feedback. In this way, working behavioral health professionals can identify service gaps and modify their policies and practices in the future.

Behavioral health advocates, too, can take action in response to the PPACA. First and foremost, advocates should continue to encourage the installation, development, or requirement for a third-party validation system for self-reporting by institutions receiving federal grants. Establishing an objective review system for all behavioral health provisions in the PPACA, universally and in a consistent, fair

manner, is one way in which greater mental health parity can be attained. Moreover, other shortfalls in the current layout of behavioral health provisions should also be brought into the public forum. Even in areas that seem to foster parity, improvements can be made in regards to requesting specific and equitable appropriation amounts, behavioral health representation in federal interagency groups, and workforce development for behavioral health professionals that is on a level equal to that of other health professions.

It is critically important that efforts to increase parity, decrease fragmentation, and overall improve the behavioral health system remain ongoing throughout the next decade, if not longer, regardless of whether the PPACA is allowed to proceed as enacted. Throughout the course of this study, it has become evident that regardless of any political roadblocks, research must continue to assess the impact of health homes and patient-centered models of care on behavioral health outcomes. At present, it is difficult to speculate on what a new, post-PPACA system of behavioral health care might look like, but it is clear that several questions remain before the behavioral health system can truly be considered reformed:

- What will happen to persons left out of coverage, such as undocumented immigrants?
- Can patients become better informed of choices and options for behavioral health care?
- Can prevention be fully defined, implemented, and legislated for behavioral health?
- Can cultural competency be established nationwide, in such a diverse and complex nation?
- Can there be true community accountability, when behavioral health institutions themselves are not held accountable to the highest level possible?

In the meantime, patients and providers alike will be waiting with bated breath to see whether Pennsylvania will win its ongoing suit to overturn the PPACA, whether any of these remaining questions can be answered over time, and whether a fully-integrated, high-quality, sustainable behavioral health is truly – finally – within their reach.

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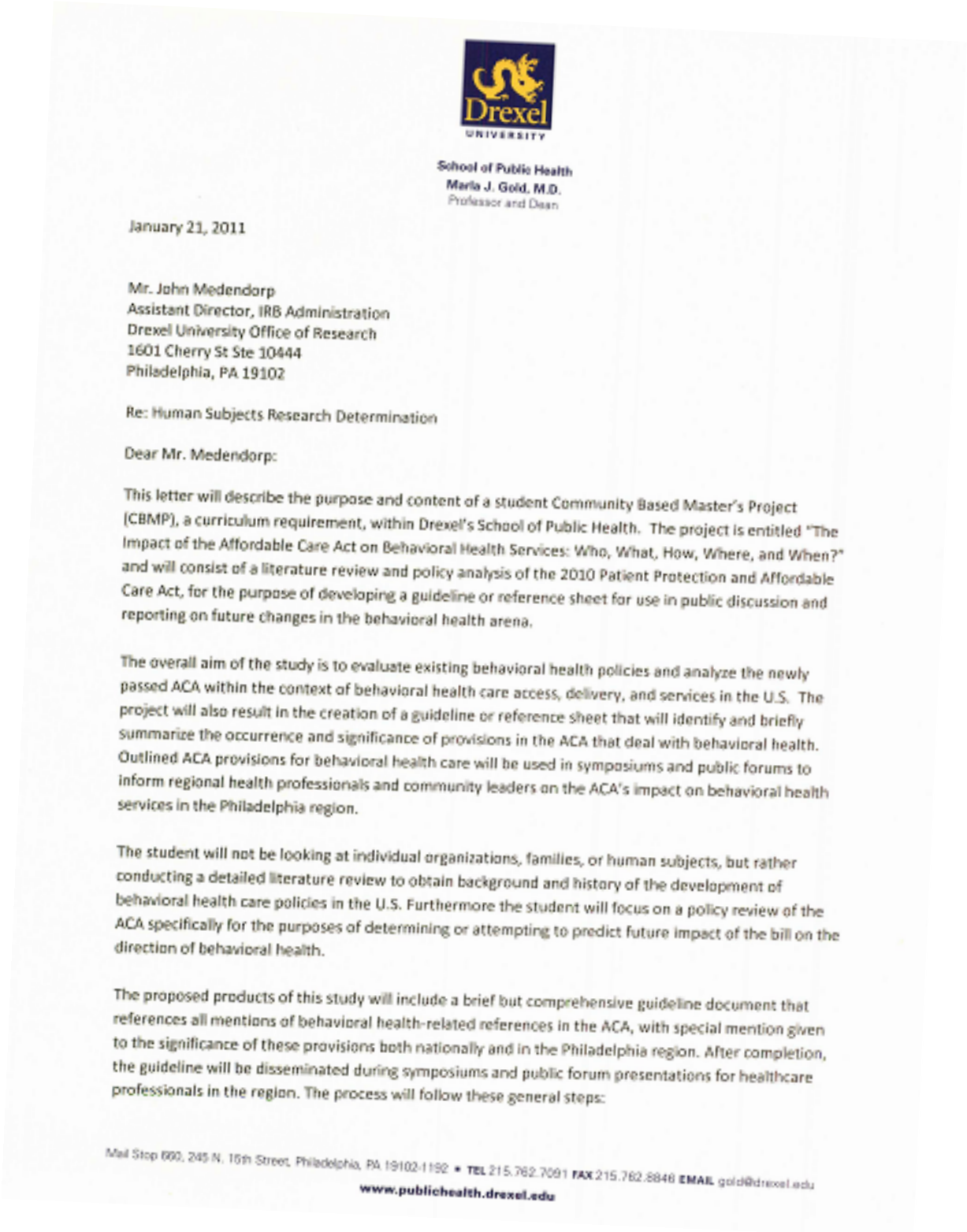
APPENDICES

Appendix A – IRB Letter of Determination



Drexel UNIVERSITY

School of Public Health
Marla J. Gold, M.D.
Professor and Dean

January 21, 2011

Mr. John Medendorp
Assistant Director, IRB Administration
Drexel University Office of Research
1601 Cherry St Ste 10444
Philadelphia, PA 19102

Re: Human Subjects Research Determination

Dear Mr. Medendorp:

This letter will describe the purpose and content of a student Community Based Master's Project (CBMP), a curriculum requirement, within Drexel's School of Public Health. The project is entitled "The Impact of the Affordable Care Act on Behavioral Health Services: Who, What, How, Where, and When?" and will consist of a literature review and policy analysis of the 2010 Patient Protection and Affordable Care Act, for the purpose of developing a guideline or reference sheet for use in public discussion and reporting on future changes in the behavioral health arena.

The overall aim of the study is to evaluate existing behavioral health policies and analyze the newly passed ACA within the context of behavioral health care access, delivery, and services in the U.S. The project will also result in the creation of a guideline or reference sheet that will identify and briefly summarize the occurrence and significance of provisions in the ACA that deal with behavioral health. Outlined ACA provisions for behavioral health care will be used in symposiums and public forums to inform regional health professionals and community leaders on the ACA's impact on behavioral health services in the Philadelphia region.

The student will not be looking at individual organizations, families, or human subjects, but rather conducting a detailed literature review to obtain background and history of the development of behavioral health care policies in the U.S. Furthermore the student will focus on a policy review of the ACA specifically for the purposes of determining or attempting to predict future impact of the bill on the direction of behavioral health.

The proposed products of this study will include a brief but comprehensive guideline document that references all mentions of behavioral health-related references in the ACA, with special mention given to the significance of these provisions both nationally and in the Philadelphia region. After completion, the guideline will be disseminated during symposiums and public forum presentations for healthcare professionals in the region. The process will follow these general steps:

Mail Stop 660, 245 N. 15th Street, Philadelphia, PA 19102-1192 • TEL 215.762.7091 FAX 215.762.8848 EMAIL gold@drexel.edu
www.publichealth.drexel.edu

1. Data will be collected via literature review to identify the current status of behavioral health care access, costs, and delivery.
2. Data analysis will consist of a thorough policy analysis of the ACA, centered on provisions for the "Who, What, How, Where, and When?" of behavioral health care in the future.
    - WHO delivers behavioral health services?
    - WHAT does behavioral health service entail, under the ACA?
    - HOW does the ACA fund or reimburse for behavioral health services?
    - WHERE will behavioral health services be delivered, under the ACA?
    - WHEN will these ACA provisions impact behavioral health services?
3. A guideline or reference sheet will be organized using data analysis findings.
4. Symposiums and forums will be organized for the purpose of informing regional health professionals and community leaders on the ACA's impact on behavioral health services in the Philadelphia area.

The student will collect data for the specific purpose of creating a historical backdrop for development of the ACA and to highlight future changes and significance of this new policy. Data collection will not involve obtaining private information from human subjects but will be based almost exclusively on existing literature and policies. The proposed project will be guided by a faculty advisor and PI for the Drexel University School of Public Health, Marla Gold, and a preceptor representing the Thomas Scattergood Behavioral Health Foundation, Joseph Pyle, who will act as consultant on this project.

If you have any questions, please feel free to contact the student, Charlene Chow, at (818)731-3204. Thank you very much for your kind attention to this matter.

Sincerely,

Marla J. Gold, MD
Dean

Appendix B – Behavioral Health-Related Terminology and Instances in the PPACA.

Behavioral Health-Related Terms	# of Mentions
"mental health"	49
"behavioral"	50
"psychiatric"	23
"psychiatry"	6
"depression"	14
"dementia"	12
TOTAL	**154**

Appendix C – Summary of Behavioral Health-Related Provisions in the PPACA, and Their Implications.

Section	Provisions	Implications
1302	Newly created 'qualified health plans' attempt to equalize the costs of premium insurance rates. Mental health services are now defined as "Essential Health Benefits."	Greater mental health parity. Expanded insurance market options, with increased enrollment and coverage leading to lower costs.
1311	Mental health coverage benefits are expanded to match medical and surgical coverage, and are extended from group health plans to PPACA qualified health plans.	Greater mental health parity.
2001	The definition of "minimum essential coverage" for Medicaid populations is expanded to include mental health services.	Greater mental health parity.
2703	Mental health is given a place in the "health home" model (a coordinated state option for patients with chronic physical and/or mental health issues who require home health care). Providers include behavioral health professionals and community mental health centers.	Greater mental health parity through behavioral health providers being afforded the same status as traditional medical & surgical care providers. Greater integration and coordination in services.

Section	Provisions	Implications
2707	Medicaid emergency psychiatric demonstration projects are established in private mental health institutions to stabilize "emergency medical conditions" (suicidal/homicidal intentions or danger to self or others). Providers are subject to Medicaid and CHIP Payment and Access Commission standards for payment. $75 million are appropriated for 2011.	More comprehensive behavioral health care, as some existing gaps in emergency mental health care are filled. Issues remain, as only stabilization services (not continuous care or follow-ups) are required, and funding mechanisms are left open-ended, antiquated, and non-standardized.
2952	Grants and insurance counseling are provided to institutions that support, educate, prevent, and research postpartum depression and psychoses. $3 million were appropriated for 2010.	Improved maternal and child mental health. Remaining issues include lack of specific amounts for appropriations.
3012	A new "Interagency Working Group on Health Care Quality" will work with SAMHSA to improve mental health care quality reporting and public-private sector alignment.	Paves the way for active steps to be taken to align public and private sectors and increase the quality of subpar behavioral health institutions in the future.
3107	Medicare physician fee schedules are extended to cover mental health.	Greater mental health parity through more equitable payment schemes & better alignment between patient health needs and physician reimbursement demands.
3502	New grants are provided for primary care-supportive programs in the patient-centered medical home. Capitated payments will be made to primary care providers & interdisciplinary health teams, which *may* include behavioral health providers.	Greater integration and coordination in access to clinical & community mental health services, esp. for children and for individuals with chronic disease. Remaining issues include the possibility that health teams will lack input from behavioral health professionals and providers.
3509	SAMHSA is *invited* to establish an Office of Women's Health for women's mental health.	Greater focus on women's behavioral health needs. Remaining issues include lack of additional funding or support to assist in the creation of this Office, which is not mandatory.
4001	A new National Prevention, Health Promotion, and Public Health Council modernizes and *integrates* health care, under guidance of the new Advisory Group on Prevention, Health Promotion, and Integrative and Public Health, which *may* include behavioral health professionals, support, and services.	Greater integration and coordination of national health priorities. Remaining issues include the possibility that the Council and Advisory Group will lack input from behavioral health professionals and providers.

Section	Provisions	Implications
4004	SAMHSA is *invited* to provide mental health resources and contribute to a new national education and outreach campaign on prevention, chronic disease, and disparities, using a customized, modernized, patient-centered model of care. $500 million are allocated in total.	Modernized mental health preventions and public health systems. Shift towards a customized, patient-centered model of care. Remaining issues include the possibility that campaign will lack input from SAMHSA, without which impacts may be insignificant.
4101	Transformation grants are awarded to school-based health centers for on-site care of Medicaid-eligible children and adolescents in underserved areas. "Comprehensive primary care services" are defined as assessments, diagnoses, treatments, referrals, and follow-ups for physical *and mental* health care.	Greater integration and coordination for increased access to behavioral health services in community and school health centers. Remaining issues include lack of specific amounts for appropriations.
4201	Transformation grants are provided to schools and communities to promote evidence-based mental health prevention and social and emotional wellness. Transformation grants are also provided for the Healthy Aging, Living Well pilot program to decrease substance abuse and conduct behavioral health screenings in Medicare populations.	Greater integration in practice. Increased quality and cost-effectiveness of mental health for Medicare populations. Remaining issues include lack of specific amounts for appropriations, and lack of outside verification for self-reporting by institutions.
5002	"Mental health service professional" is defined to include graduates of accredited psychiatry, psychology, behavioral pediatrics, psychiatric nursing, social work, and school counseling institutions. "Graduate psychology" is recognized as a valid health training field. "Paraprofessional child and adolescent mental health workers" are not explicitly defined but are recognized as the first point-of-contact for individuals seeking mental health care.	Important definitions for the behavioral health workforce.
5101	A new National Healthcare Workforce Commission assesses barriers to integrated care, workforce shortages, education, and training. "Health professionals" now include social workers, psychologists, substance abuse providers, and other mental health professionals. Mental health workers are officially designated as part of the "health care workforce."	Greater integration, at least by definition. Remaining issues include lack of specific amounts for appropriations, and the possibility that Workforce Commission will lack input from behavioral health professionals and providers.

Section	Provisions	Implications
5203	New pediatric specialty loan repayment programs encourage pediatric specialists to provide child and adolescent mental health care in medically underserved areas. "Qualified medical professional" fields include psychiatry, psychology, social work, behavioral pediatrics, psychiatric nursing, marriage and family therapy, school or professional counseling, and substance abuse services. $20 million are appropriated annually from 2010-2013.	Paves the way for evidence-based, culturally sensitive mental health care in medically underserved areas and school environments. Remaining issues include the lack of political and financial parity for reimbursements for behavioral health versus medical and surgical health services.
5301	New grants are provided to medical schools for interdisciplinary, integrative models of primary care (i.e. patient-centered medical home, chronic disease management teams, and interprofessional care systems). $125 million are appropriated for 2010.	Greater integration and coordination of behavioral health services as a part of primary care, esp. in underserved or vulnerable populations. Remaining issues include lack of specific amounts for appropriations (only for behavioral health).
5306	Behavioral health education and training grants are provided through 2013 to recruit, educate, and train such students. Social work programs receive up to $8 million, psychology programs $10-12 million, and child and adolescent mental health programs $5-10 million.	Greater cultural sensitivity. Greater focus on workforce education that targets collaborative service in underserved areas. Remaining issues include insufficient time allotted for appropriations to make an impact.
5315	The new U.S. Public Health Services Track, located in pre-existing academic health centers, will bestow grants & degrees related to public health and interdisciplinary service, and will graduate no less than 100 behavioral health professionals annually. Training for behavioral health students must be comparable to that for traditional medical students.	Greater parity in mental health education, training, and workforce composition. Greater integration and cooperation, with a broadening, interdisciplinary, community-based focus on continuous and culturally sensitive care. Remaining issues include incomplete parity, with fewer required graduates for behavioral than for medical and nursing health professions.
5508	New development grants for teaching health institutions (and community mental health centers) expand primary care residency programs to include psychiatry. $230 million are appropriated from 2010-2015.	Re-definition of primary care to include psychiatry. Remaining issues include lack of outside verification for self-reporting by institutions.

Section	Provisions	Implications
5604	New grants for community mental health centers establish demonstration projects to co-locate primary and specialty care. "Special populations" include adults with mental illnesses with co-occurring chronic or primary care conditions. $50 million are appropriated for 2010.	Greater integration. Remaining issues include lack of outside verification for self-reporting by institutions.
6703	The Elder Justice Act of 2009 protects elderly in community-based care facilities (i.e. community mental health centers) who are mentally incapable of obtaining goods and services to maintain their own mental health – in other words, those who "self-neglect."	Greater integration and cooperation, at least in definition, with mental health being an interdisciplinary component of overall wellness and justice. Remaining issues include minimal focus of mental health in elder care, outside of self-neglect.
10334	The new Office of Minority Health installs offices of minority health in DHHS agencies (i.e. SAMHSA) to evaluate and enhance racial and cultural competency in minority health care.	Paves the way for greater cultural sensitivity and culturally appropriate care. Remaining issues include the diversion of funds for office creation from other SAMHSA programs.
10410	The ENHANCED Act of 2009 establishes a National Coordinating Center and network of many Centers of Excellence for Depression. "Depressive disorder" is defined as a mental or brain disorder linked to major depression, bipolar disorder, and similar mood disorders. New grants are provided to entities with comprehensive services for mental health professional training, depressive disorders, and co-occurring mental illnesses. $100 million are appropriated annually from 2010-2015, and $150 million from 2016-2020.	Greater integration and cooperation between mental, primary care, and primary preventions, with an interdisciplinary focus on education, training, modernization, evidence-based practices, and translational research. Remaining issues include potentially ineffective use of grant funds, which are invested into already well-developed facilities, and incomplete performance evaluation, with a third-party review for the network of Centers and a lack of third-party review of individual Centers.

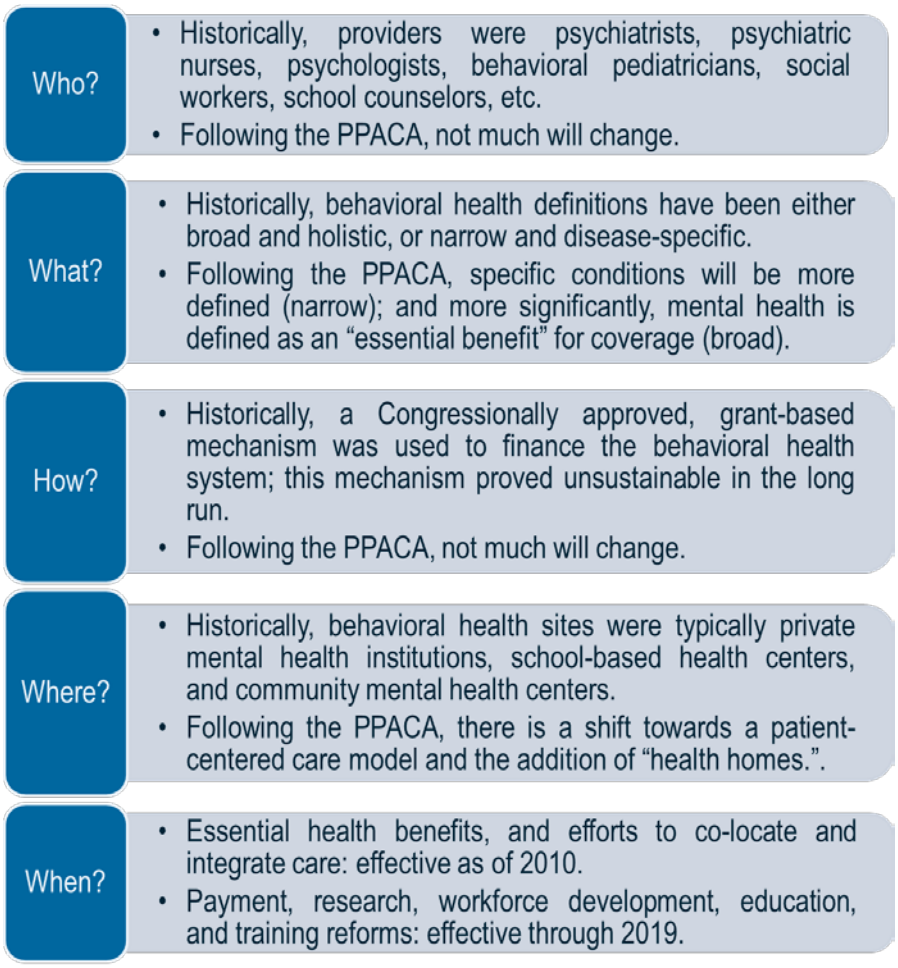
Appendix D – Summary of Recurring Themes for Behavioral Health

Themes	Sections
Greater integration, coordination, and interdisciplinary cooperation	2703, 3502, 4001, 4004, 4101, 4201, 5101, 5203, 5301, 5315, 5604, 6703, 10410
Emphasis on vulnerable, underserved populations	2952, 3502, 3509, 4201, 5301, 5306, 6703
Greater mental health parity	1302, 1311, 2001, 2703, 3107, 5315
Attention to research and cost-effective preventions	2952, 4001, 4004, 4201, 10410
Attention to culturally-appropriate care	5306, 5315, 10334
Attention to behavioral health workforce education and training	5101, 5203, 5301, 5306, 5315, 5508

Appendix E – Summary of Recurring Limitations for Behavioral Health

Themes	Sections
Vague, unspecified, disparate, or nonexistent monetary amounts for appropriations	2707, 2952, 3509, 4101, 4201, 5101, 5301, 10334
Potential for a lack of behavioral health involvement or input	3502, 4001, 4004, 5101
Lack of third-party, independent review system for program evaluations	5508, 5604, 10410

Appendix F – Summary of the PPACA's Impact on Historic Issues in Behavioral Health



Appendix G – Recommendations for Future Focus by Behavioral Health Professionals

	Recommended Actions
Behavioral Health Providers	1. Begin to co-locate services for primary and behavioral health care. 2. Invest heavily in education and training, particularly for culturally-competent, patient-centered models of care. 3. Improve internal standards for workforce recruitment, quality review, and reporting, in order to identify and fill service gaps. • Develop a bilingual behavioral health staff, as well as a culturally-relevant system for collecting and using patient-level data. • Begin with a baseline assessment of an institution's ability to meet patient-level needs. • Use aggregate patient-level data to modify programs and initiatives to meet the needs of the broader population. • Implement a reporting system that invites community feedback.

Behavioral Health Advocates	1. Encourage the installation, development, or requirement for a third-party validation system for self-reporting by institutions receiving federal grants. 2. Demand specific and equitable appropriation amounts. 3. Demand behavioral health representation in federal interagency and interdisciplinary groups. 4. Demand workforce development for behavioral health professionals that is on a level equal to that of other health professions.
Behavioral Health Researchers	1. Focus on areas of research as dictated by the PPACA. 2. Address remaining questions, such as: • What will happen to those without coverage, like undocumented immigrants? • Can prevention be fully defined, implemented, and legislated? • Can cultural competency be established nationwide, in such a diverse and complex nation? • Can there be true community accountability, when behavioral health institutions themselves are not held accountable to the highest level possible in the PPACA?